STATE OF MISSOURI



PERSONAL CARE MANUAL

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SECTION 1-PARTICIPANT CONDITIONS OF PARTICIPATION

1.1 INDIVIDUALS ELIGIBLE FOR MO HEALTHNET, MANAGED CARE OR STATE FUNDED BENEFITS

MO HealthNet benefits are available to individuals who are determined eligible by the local Family Support Division (FSD) office. Each eligibility group or category of assistance has its own eligibility determination criteria that *must* be met. Some eligibility groups or categories of assistance are subject to Day Specific Eligibility and some are *not* (refer to Section 1.6.A).

1.1.A DESCRIPTION OF ELIGIBILITY CATEGORIES

The following list includes a simple description and applicable ME codes for all categories of assistance:

1.1.A(1) MO HealthNet

ME CODE	DESCRIPTION
01, 04, 11, 12, 13, 14, 15, 16	Elderly, blind and disabled individuals who meet the MO HealthNet eligibility criteria in the community or a vendor facility; or receive a Missouri State Supplemental Conversion or Supplemental Nursing Care check.
03	Individuals who receive a Supplemental Aid to the Blind check or a Missouri State Supplemental check based on blindness.
55	Individuals who qualify to have their Medicare Part B Premiums paid by the state. These individuals are eligible for reimbursement of their Medicare deductible coinsurance and copay amounts only for Medicare covered services.
18, 43, 44, 45, 61	Pregnant women who meet eligibility factors for the MO HealthNet for Pregnant Women Program.
10, 19, 21, 24, 26	Individuals eligible for MO HealthNet under the Refugee Act of 1980 or the Refugee Education Assistance Act of 1980.

23, 41	Children in a Nursing Facility/ICF/MR.
28, 49, 67	Children placed in foster homes or residential care by DMH.
33, 34	Missouri Children with Developmental Disabilities (Sarah Jean Lopez) Waiver.
81	Temporary medical eligibility code. Used for individuals reinstated to MHF for 3 months (January-March, 2001), due to loss of MO HealthNet coverage when their TANF cases closed between December 1, 1996 and February 29, 2000. Used for White v. Martin participants and used for BCCT.
83	Women under age 65 determined eligible for MO HealthNet based on Breast or Cervical Cancer Treatment (BCCT) Presumptive Eligibility.
84	Women under age 65 determined eligible for MO HealthNet based on Breast or Cervical Cancer Treatment (BCCT).
85	Ticket to Work Health Assurance Program (TWHAP) participants--premium
86	Ticket to Work Health Assurance Program (TWHAP) participants--non-premium

1.1.A(2) MO HealthNet for Kids

ME CODE	DESCRIPTION
05, 06	Eligible children under the age of 19 in MO HealthNet for Families (based on 7/96 AFDC criteria) and the eligible relative caring for the children including families eligible for Transitional MO HealthNet.

60	Newborns (infants under age 1 born to a MO HealthNet or managed care participant).
40, 62	Coverage for non-CHIP children up to age 19 in families with income under the applicable poverty standard.
07, 29, 30, 37, 38, 50, 63, 66, 68, 69, 70	Children in custody of the Department of Social Services (DSS) Children's Division who meet Federal Poverty Level (FPL) requirements and children in residential care or foster care under custody of the Division of Youth Services (DYS) or Juvenile Court who meet MO HealthNet for Kids non-CHIP criteria.
36, 56	Children who receive a federal adoption subsidy payment.
71, 72	Children's Health Insurance Program covers uninsured children under the age of 19 in families with gross income above the non-CHIP limits up to 150% of the FPL. (Also known as MO HealthNet for Kids.)
73	Covers uninsured children under the age of 19 in families with gross income above 150% but less than 185% of the FPL. (Also known as MO HealthNet for Kids.) There is a premium.
74	Covers uninsured children under the age of 19 in families with gross income above 185% but less than 225% of the FPL. (Also known as MO HealthNet for Kids.) There is a premium.

75	Covers uninsured children under the age of 19 in families with gross income above 225% of the FPL up to 300% of the FPL. (Also known as MO HealthNet for Kids.) Families *must* pay a monthly premium. There is a premium.
87	Children under the age of 19 determined to be presumptively eligible for benefits prior to having a formal eligibility determination completed.

1.1.A(3) Temporary MO HealthNet During Pregnancy (TEMP)

ME CODE	DESCRIPTION
58	Pregnant women who qualify under the Presumptive Eligibility (TEMP) Program receive limited coverage for ambulatory prenatal care while they await the formal determination of MO HealthNet eligibility.
59	Pregnant women who received benefits under the Presumptive Eligibility (TEMP) Program but did *not* qualify for regular MO HealthNet benefits after the formal determination. The eligibility period is from the date of the formal determination until the last day of the month of the TEMP card or shown on the TEMP letter. NOTE: Providers should encourage women with a TEMP card to apply for regular MO HealthNet.

1.1.A(4) Voluntary Placement Agreement for Children

ME CODE	DESCRIPTION
88	Children seventeen (17) years of age or younger in need of mental health treatment whose parent, legal guardian or custodian has signed an out-of-home care Voluntary

Placement Agreement (VPA) with the Department of Social Services (DSS) Children's Division.

1.1.A(5) State Funded MO HealthNet

ME CODE	DESCRIPTION
02	Individuals who receive a Blind Pension check.
08	Children and youth under age 21 in DSS Children's Division foster homes or who are receiving state funded foster care.
52	Children who are in the custody of the Division of Youth Services (DYS-GR) who do *not* meet MO HealthNet for Kids non-CHIP criteria. (NOTE: GR in this instance means general revenue as services are provided by all state funds. Services are *not* restricted.)
57	Children who receive a state only adoption subsidy payment.
64	Children who are in the custody of Juvenile Court who do *not* qualify for federally matched MO HealthNet under ME codes 30, 69 or 70.
65	Children placed in residential care by their parents, if eligible for MO HealthNet on the date of placement.

1.1.A(6) MO Rx

ME CODE	DESCRIPTION
82	Participants only have pharmacy Medicare Part D wrap-around benefits through the MoRx.

1.1.A(7) Women's Health Services

ME CODE	DESCRIPTION
80	Uninsured women, ages 18 through 55, who do *not* qualify for other benefits, and lose their MO HealthNet for Pregnant Women eligibility 60 days after the birth of their child, will continue to be eligible for family planning and limited testing and treatment of Sexually Transmitted Diseases for up to one (1) year if the family income is at or below 196% of the Federal poverty level (FPL), and who are not otherwise eligible for MO HealthNet, the Children's Health Insurance Program (CHIP), Medicare, or health insurance coverage that provides family planning services.
89	Women's Health Services Program provides family planning and limited testing and treatment of Sexually Transmitted Diseases to women, ages 18 through 55, who have family income at or below 201% of the Federal poverty level (FPL), and who are not otherwise eligible for MO HealthNet, the Children's Health Insurance Program (CHIP), Medicare, or health insurance coverage that provides family planning services.

1.1.A(8) ME Codes Not in Use

The following ME codes are *not* currently in use:

09, 17, 20, 22, 25, 27, 31, 32, 35, 39, 42, 46, 47, 48, 51, 53, 54, 76, 77, 78, 79

1.2 MO HEALTHNET AND MO HEALTHNET MANAGED CARE ID CARD

The Department of Social Services issues a MO HealthNet ID card for each MO HealthNet or managed care eligible participant. For example, the eligible caretaker and each eligible child

receives his/her own ID card. Providers *must* use the card that corresponds to each individual/child to verify eligibility and determine any other pertinent information applicable to the participant. Participants enrolled in a MO HealthNet managed health care plan also receive an ID card from the managed health care plan. (Refer to Section 1.2.C for a listing of MO HealthNet/MO HealthNet Managed Care Eligibility (ME) codes identifying which individuals are to receive services on a fee-for-service basis and which individuals are eligible to enroll in a managed health care plan.

An ID card *does **not** show eligibility dates or any other information regarding restrictions of benefits or Third Party Resource (TPR) information.* Providers *must* verify the participant's eligibility status before rendering services as the ID card only contains the participant's identifying information (ID number, name and date of birth). As stated on the card, *holding the card does not certify eligibility or guarantee benefits***.**

The local Family Support Division (FSD) office issues an approval letter for each individual or family at the time of approval to be used in lieu of the ID card until the permanent ID card can be mailed and received by the participant. The card should normally be received within a few days of the Eligibility Specialist's action. Replacement letters are also furnished when a card has been lost, destroyed or stolen until an ID card is received in the mail. Providers may accept these letters to verify the participant's ID number.

The card carrier mailer notifies participants *not* to throw the card away as they will *not* receive a new ID card each month. The participant *must* keep the ID card for as long as the individual named on the card qualifies for MO HealthNet or managed care. Participants who are eligible as spenddown participants are encouraged to keep the ID card to use for subsequent spenddown periods. Replacement cards are issued whenever necessary as long as the participant remains eligible.

Participants receive a new ID card within a few days of the Eligibility Specialist's action under the following circumstances:

- The participant is determined eligible or regains eligibility;
- The participant has a name change;
- A file correction is made to a date of birth which was invalid at time of card issue; or
- The participant reports a card as lost, stolen or destroyed.

1.2.A FORMAT OF MO HEALTHNET ID CARD

The plastic MO HealthNet ID card will be red if issued prior to January 1, 2008 or white if issued on or after January 1, 2008. Each card contains the participant's name, date of birth and MO HealthNet ID number. The reverse side of the card contains basic information and the Participant Services Hotline number.

An ID card does not guarantee benefits. It is important that the provider always check eligibility and the MO HealthNet/Managed Care Eligibility (ME) code on file for the date of

service. The ME code helps the provider know program benefits and limitations including copay requirements.

1.2.B ACCESS TO ELIGIBILITY INFORMATION

Providers *must* verify eligibility via the Internet or by using the interactive voice response (IVR) system by calling (573) 751-2896 and keying in the participant ID number shown on the face of the card. Refer to Section 3 for information regarding the Internet and the IVR inquiry process.

Participants may be subject to Day Specific Eligibility. Refer to Section 1.6.A for more information.

1.2.C IDENTIFICATION OF PARTICIPANTS BY ELIGIBILITY CODES

1.2.C(1) MO HealthNet Participants

The following ME codes identify people who get a MO HealthNet approval letter and MO HealthNet ID card:

01, 02, 03, 04, 11, 12, 13, 14, 15, 16, 23, 28, 33, 34, 41, 49, 55, 67, 83, 84, 89

1.2.C(2) MO HealthNet Managed Care Participants

MO HealthNet Managed Care refers to:

- some adults and children who used to get a MO HealthNet ID card
- people eligible under the MO HealthNet for Kids (SCHIP) and the uninsured parent's program
- people enrolled in a MO HealthNet managed care health plan*

The following ME codes identify people who get a MO HealthNet Managed Care health insurance approval letter and MO HealthNet Managed Care ID Card

05, 06, 07, 08, 10, 18, 19, 21, 24, 26, 29, 30, 36, 37, 40, 43, 44, 45, 50, 52, 56, 57, 60, 61, 62, 63, 64, 65, 66, 68, 69, 70, 71, 72, 73, 74, 75

*An individual may be eligible for managed care and *not* be in a MO HealthNet managed care health plan because they do *not* live in a managed care health plan area. Individuals enrolled in MO HealthNet Managed Care also get a MO HealthNet Managed Care health plan card issued by the managed care health plan. Refer to Section 11 for more information regarding Missouri's managed care program.

1.2.C(3) TEMP

A pregnant woman who has *not* applied for MO HealthNet can get a white temporary MO HealthNet ID card. The TEMP card provides limited benefits

during pregnancy. The following ME codes identify people who have TEMP eligibility:

58, 59

1.2.C(4) Temporary Medical Eligibility for Reinstated TANF Individuals

Individuals who stopped getting a Temporary Assistance for Needy Families (TANF) cash grant between December 1, 1996 and February 29, 2000 and lost their MO HealthNet/MO HealthNet Managed Care benefits had their medical benefits reinstated for three months from January 1, 2001 to March 31, 2001.

ME code 81 identifies individuals who received an eligibility letter from the Family Support Division. These individuals are *not* enrolled in a MO HealthNet managed care health plan.

1.2.C(5) Presumptive Eligibility for Children

Children in families with income below 150% of the Federal Poverty Level (FPL) determined eligible for MO HealthNet benefits prior to having a formal eligibility determination completed by the Family Support Division (FSD) office. The families receive a MO HealthNet for Kids Presumptive Eligibility Authorization (PC-2) notice which includes the MO HealthNet for Kids number(s) and effective date of coverage.

ME code 87 identifies children determined eligible for Presumptive Eligibility for Children.

1.2.C(6) Breast or Cervical Cancer Treatment Presumptive Eligibility

Women determined eligible by the Department of Health and Senior Services' Breast and Cervical Cancer Control Project (BCCCP) or the Breast or Cervical Cancer Treatment (BCCT) Presumptive Eligibility (PE) Program receive a BCCT Temporary MO HealthNet Authorization letter which provides for limited MO HealthNet benefits while they wait for a formal eligibility determination by the FSD.

ME code 83 identifies women receiving benefits through BCCT PE.

1.2.C(7) Voluntary Placement Agreement

Children determined eligible for out-of-home care, per a signed Voluntary Placement Agreement (VPA), require medical planning and are eligible for a variety of children's treatment services, medical and psychiatric services. The Children's Division (CD) worker makes appropriate referrals to CD approved

contractual treatment providers. Payment is made at the MO HealthNet or state contracted rates.

ME code 88 identifies children receiving coverage under a VPA.

1.2.D THIRD PARTY INSURANCE COVERAGE

When the MO HealthNet Division (MHD) has information that the participant has third party insurance coverage, the relationship code and the full name of the third party coverage are identified. The address information can be obtained through emomed. A provider *must* always bill the other insurance before billing MO HealthNet unless the service qualifies as an exception as specified in Section 5. For additional information, contact Provider Communications at (573) 751-2896 or the TPL Unit at (573) 751-2005.

NOTE: The provider *must* always ask the participant if they have third party insurance regardless of information on the participant file. *It is the provider's responsibility to obtain from the participant the name and address of the insurance company, the policy number, policy holder and the type of coverage.* See Section 5, Third Party Liability.

1.2.D(1) Medicare Part A, Part B and Part C

The eligibility file (IVR/Internet) provides an indicator if the MO HealthNet Division has information that the participant is eligible for Medicare Part A, Part B and/or Medicare Part C.

NOTE: The provider *must* always ask the participant if they have Medicare coverage, regardless of information on the participant file. It is also important to identify the participant's type of Medicare coverage. Part A provides for nursing home, inpatient hospital and certain home health benefits; Part B provides for medical insurance benefits; and Part C provides the services covered under Part A and Part B through a Medicare Advantage Plan (private companies approved by Medicare). When MO HealthNet is secondary to Medicare Part C, a crossover claim for coinsurance, deductible and copay may be reimbursed for participants who have MO HealthNet QMB (reference Section 1.5.E). For non-QMB participants enrolled in a Medicare Advantage/Part C Plan, MO HealthNet secondary claims will process in accordance with the established MHD coordination of benefits policy (reference Section 5.1.A).

1.3 MO HEALTHNET, STATE FUNDED MEDICAL ASSISTANCE AND MO HEALTHNET MANAGED CARE APPLICATION PROCESS

If a patient who has *not* applied for MO HealthNet, state funded Medical Assistance or MO HealthNet Managed Care benefits is unable to pay for services rendered and appears to meet

eligibility requirements, the provider should encourage the patient or the patient's representative (related or unrelated) to apply for benefits through the Family Support Division in the patient's county of residence. Information can also be obtained by calling the FSD Call Center at (855) 373-4636. Applications for MO HealthNet Managed Care may be requested by phone by calling (888) 275-5908. The county office accepts and processes the application and notifies the patient of the resulting determination.

Any individual authorized by the participant may make application for MO HealthNet Managed Care, MO HealthNet and other state funded Medical Assistance on behalf of the client. This includes staff members from hospital social service departments, employees of private organizations or companies, and any other individual designated by the client. Clients *must* authorize non-relative representatives to make application for them through the use of the IM Authorized Representative form. A supply of this form and instructions for completion may be obtained from the Family Support Division county office.

1.4 AUTOMATIC MO HEALTHNET ELIGIBILITY FOR NEWBORN CHILDREN

A child born to a woman who is eligible for and is receiving MO HealthNet or under a federally funded program on the date the child is born is automatically eligible for MO HealthNet. Federally funded MO HealthNet programs that automatically cover newborn children are MO HealthNet for Families, Pregnant Women, Supplemental Nursing Care, Refugee, Supplemental Aid to the Blind, Supplemental Payments, MO HealthNet for Children in Care, Children's Health Insurance Program, and Uninsured Parents.

Coverage begins on the date of birth and extends through the date the child becomes one year of age as long as the mother remains continuously eligible for MO HealthNet or who would remain eligible if she were still pregnant and the child continues to live with the mother.

Notification of the birth should be sent immediately by the mother, physician, nurse-midwife, hospital or managed care health plan to the Family Support Division office in the county in which the mother resides and should contain the following information:

- The mother's name and MO HealthNet or Managed Care ID number
- The child's name, birthdate, race, and sex
- Verification of birth.

If the mother notifies the Family Support Division office of the birth, that office verifies the birth by contacting the hospital, attending physician, or nurse-midwife.

The Family Support Division office assigns a MO HealthNet ID number to the child as quickly as possible and gives the ID number to the hospital, physician, or nurse-midwife. Family Support Division staff works out notification and verification procedures with local hospitals.

The Family Support Division office explores the child's eligibility for other types of assistance beyond the newborn policy. However, the eligibility determination for another type of assistance does *not* delay or prevent the newborn from being added to the mother's case when the Family Support Division staff is notified of the birth.

1.4.A NEWBORN INELIGIBILITY

The automatic eligibility for newborns is *not* available in the following situations:

- The mother is eligible under the Blind Pension (state-funded) category of assistance.
- The mother has a pending application for assistance but is *not* receiving MO HealthNet at the time of the child's birth.
- The mother has TEMP eligibility, which is *not* considered regular MO HealthNet eligibility. If the mother has applied for and has been approved for a federally funded type of assistance at the time of the birth, however, the child is automatically eligible.
- MO HealthNet spenddown: if the mother's spenddown amount has *not* been met on the day of the child's birth, the child is *not* automatically eligible for MO HealthNet. If the mother has met her spenddown amount prior to or on the date of birth, the child is automatically eligible. Once the child is determined automatically eligible, they remain eligible, regardless of the mother's spenddown eligibility.
- Emergency Medical Care for Ineligible Aliens: The delivery is covered for the mother, however the child is *not* automatically eligible. An application *must* be filed for the newborn for MO HealthNet coverage and *must* meet CHIP or non-CHIP eligibility requirements.
- Women covered by the Extended Women's Health Services Program.

1.4.B NEWBORN ADOPTION

MO HealthNet coverage for an infant whose birth mother intends to relinquish the child continues from birth until the time of relinquishment if the mother remains continuously eligible for MO HealthNet or would if still pregnant during the time that the child continues to live with the mother. This includes the time period in which the child is in the hospital, unless removed from mother's custody by court order.

1.4.C MO HEALTHNET MANAGED CARE HEALTH PLAN NEWBORN ENROLLMENT

The managed care health plan *must* have written policies and procedures for enrolling the newborn children of program members effective to the time of birth. Newborns of program eligible mothers who were enrolled at the time of the child's birth are automatically enrolled with the mother's managed care health plan. The managed care health plan should have a procedure in place to refer newborns to an enrollment counselor or Family Support Division to initiate eligibility determinations or enrollment procedures as appropriate. A mother of a newborn may choose a different managed care health plan for her child; unless a different managed care health plan is requested, the child remains with the mother's managed care health plan.

- Newborns are enrolled with the mother's managed care health plan unless a different managed care health plan is specified.
- The mother's managed care health plan shall be responsible for all medically necessary services provided under the standard benefit package to the newborn child of an enrolled mother. The child's date of birth shall be counted as day one. When the newborn is assigned an ID number, the managed care health plan shall provide services to the child until the child is disenrolled from the managed care health plan. The managed care health plan shall receive capitation payment for the month of birth and for all subsequent months the child remains enrolled with the managed care health plan.
- If there is an administrative lag in enrolling the newborn and costs are incurred during that period, it is essential that the participant be held harmless for those costs. The managed care health plan is responsible for the cost of the newborn.

1.5 PARTICIPANTS WITH RESTRICTED/LIMITED BENEFITS

Participants may have restricted or limited benefits, be subject to administrative lock-in, be managed care enrollees, be hospice beneficiaries or have other restrictions associated with their category of assistance.

It is the provider's responsibility to determine if the participant has restricted or limited coverage. Restrictions can be added, changed or deleted at any time during a month. The following information is furnished to assist providers to identify those participants who may have restricted/limited benefits.

1.5.A LIMITED BENEFIT PACKAGE FOR ADULT CATEGORIES OF ASSISTANCE

Senate Bill 539 was passed by the 93rd General Assembly and became effective August 28, 2005. Changes in MO HealthNet Program benefits were effective for dates of service on or after September 1, 2005. The bill eliminated certain optional MO HealthNet services for

individuals age 21 and over that are eligible for MO HealthNet under one of the following categories of assistance:

ME CODE	DESCRIPTION
01	MO HealthNet for the Aged
04	Permanently and Totally Disabled (APTD)
05	MO HealthNet for Families - Adult (ADC-AD)
10	Vietnamese or Other Refugees (VIET)
11	MO HealthNet - Old Age (MHD-OAA)
13	MO HealthNet - Permanently and Totally Disabled (MHD-PTD)
14	Supplemental Nursing Care - MO HealthNet for the Aged
16	Supplemental Nursing Care - PTD (NC-PTD)
19	Cuban Refugee
21	Haitian Refugee
24	Russian Jew
26	Ethiopian Refugee
83	Presumptive Eligibility - Breast or Cervical Cancer Treatment (BCCT)
84	Regular Benefit - Breast or Cervical Cancer Treatment (BCCT)
85	Ticket to Work Health Assurance Program (TWHAP) --premium
86	Ticket to Work Health Assurance Program (TWHAP) -- non-premium

MO HealthNet coverage for the following programs or services has been eliminated or reduced for adults with a limited benefit package. Providers should refer to Section 13 of the applicable provider manual for specific restrictions or guidelines.

- Comprehensive Day Rehabilitation
- Dental Services
- Diabetes Self-Management Training Services
- Hearing Aid Program
- Home Health Services
- Outpatient Therapy
- Physician Rehabilitation Services
- Podiatry Services

NOTE: MO HealthNet participants residing in nursing homes are able to use their surplus to pay for federally mandated medically necessary services. This may be done by adjudicating claims through the MO HealthNet claims processing system to ensure best price, quality, and program integrity. MO HealthNet participants receiving home health services receive all federally mandated medically necessary services. MO HealthNet children and those in the assistance categories for pregnant women or blind participants are *not* affected by these changes.

1.5.B ADMINISTRATIVE PARTICIPANT LOCK-IN

Some MO HealthNet participants are restricted or locked-in to authorized MO HealthNet providers of certain services to help the participant use the MO HealthNet Program properly. When the participant has an administrative lock-in provider, the provider's name and telephone number are identified on the Internet or IVR when verifying eligibility.

Payment of services for a locked-in participant is *not* made to unauthorized providers for other than emergency services or authorized referral services. Emergency services are only considered for payment if the claim is supported by medical records documenting the emergency circumstances.

When a physician is the designated/authorized provider, they are responsible for the participant's primary care and for making necessary referrals to other providers as medically indicated. When a referral is necessary, the authorized physician *must* complete a Medical Referral Form of Restricted Participant (PI-118) and send it to the provider to whom the participant is referred. *This referral is good for 30 days only* from the date of service. This form *must* be mailed or submitted via the Internet (Refer to Section 23) by the unauthorized provider. The Referred Service field should be completed on the claim form. These referral forms are available on the Missouri Medicaid Audit and Compliance (MMAC) website at www.MMAC.MO.GOV or from MMAC, Provider Review & Lock-In Section, P.O. Box 6500, Jefferson City, Missouri 65102.

If a participant presents an ID card that has administrative lock-in restrictions to other than the authorized provider and the service is *not* an emergency, an authorized referral, or if a provider feels that a participant is improperly using benefits, the provider is requested to notify MMAC Provider Review, P.O. Box 6500, Jefferson City, Missouri 65102.

1.5.C MO HEALTHNET MANAGED CARE PARTICIPANTS

Participants who are enrolled in MO HealthNet's Managed Care programs are identified on the Internet or IVR when verifying eligibility. The response received identifies the name and phone number of the participant's selected managed care health plan. The response also includes the identity of the participant's primary care provider in the managed care program areas. Participants who are eligible for MO HealthNet and who are enrolled with a managed

care health plan *must* have their basic benefit services provided by or prior authorized by the managed care health plan.

MO HealthNet Managed Care health plans may also issue their own individual health plan ID cards. The individual *must* be eligible for MO HealthNet and enrolled with the managed care health plan on the date of service for the managed care health plan to be responsible for services. MO HealthNet eligibility dates are different from managed care health plan enrollment dates. Managed care enrollment can be effective on any date in a month. Sometimes a participant may change managed care health plans and be in one managed care health plan for part of the month and another managed care health plan for the remainder of the month. Managed care health plan enrollment can be verified by the IVR/Internet.

Providers *must* verify the eligibility status including the participant's ME code and managed care health plan enrollment status on all MO HealthNet participants before providing service.

The following information is provided to assist providers in determining those participants who are eligible for inclusion in MO HealthNet Managed Care Programs. The participants who are eligible for inclusion in the health plan are divided into five groups.* Refer to Section 11 for a listing of included counties and the managed care benefits package.

- Group 1 and 2 have been combined and are referred to as Group 1. Group 1 generally consists of the MO HealthNet for Families population (both the caretaker and child[ren]), the children up to age 19 of families with income under the applicable poverty standard, Refugee MO HealthNet participants and pregnant women. NOTE: Previous policy stated that participants over age 65 were exempt from inclusion in managed care. There are a few individuals age 65 and over who are caretakers or refugees and who do *not* receive Medicare benefits and are therefore included in managed care.

  The following ME codes fall into Group 1: 05, 06, 10, 18, 19, 21, 24, 26, 40, 43, 44, 45, 60, 61 and 62.

- *Group 3 previously consisting of General Relief participants has been deleted from inclusion in the managed care program at this time.*

- Group 4 generally consists of those children in state care and custody. The following ME codes fall into this group: 07, 08, 29, 30, 36, 37, 38, 50, 52, 56, 57, 63, 64, 66, 68, 69, 70, and 88.

- Group 5 consists of uninsured children.

  The following ME codes for uninsured children are included in Group 5: 71, 72, 73, 74 and 75.

* Participants who are identified as eligible for inclusion in the managed care program are *not* enrolled with a managed care health plan until 15 days after they actually select or are assigned to a managed care health plan. When the selection or assignment is in effect, the name of the managed care health plan appears on the IVR/Internet

information. If a managed care health plan name does *not* appear for a particular date of service, the participant is in a fee-for-service status for each date of service that a managed care health plan is *not* listed for the participant.

"OPT" OUT POPULATIONS: The Department of Social Services is allowing participants, who are currently in the managed care program because they receive SSI disability payments, who meet the SSI disability definition as determined by the Department of Social Services, or who receive adoption subsidy benefits, the option of choosing to receive services on a fee-for-service basis or through the managed care program. The option is entirely up to the participant, parent or guardian.

1.5.C(1) Home Birth Services for the MO HealthNet Managed Care Program

If a managed care health plan member elects a home birth, the member may be disenrolled from the managed care program at the request of the managed care health plan. The disenrolled member then receives all services through the fee-for-service program.

The member remains disenrolled from the managed care health plan if eligible under the MO HealthNet for Pregnant Women category of assistance. If the member is *not* in the MO HealthNet for Pregnant Women category and is disenrolled for the home birth, she is enrolled/re-enrolled in a managed care health plan six weeks post-partum or after a hospital discharge, whichever is later. The baby is enrolled in a managed care health plan once a managed care health plan number is assigned or after a hospital discharge, whichever is later.

1.5.D HOSPICE BENEFICIARIES

MO HealthNet participants *not* enrolled with a managed care health plan who elect hospice care are identified as such on the Internet or IVR. The name and telephone number of the hospice provider is identified on the Internet or IVR.

Hospice care is palliative *not* curative. It focuses on pain control, comfort, spiritual and emotional support for a terminally ill patient and his or her family. To receive MO HealthNet covered hospice services the participant *must*:

- be eligible for MO HealthNet on all dates of service;
- be certified by two physicians (M.D. or D.O.) as terminally ill and as having less than six months to live;
- elect hospice services and, if an adult, waive active treatment for the terminal illness; and
- obtain all services related to the terminal illness from a MO HealthNet-participating hospice provider, the attending physician, or through arrangements by the hospice.

When a participant elects the hospice benefit, the hospice assumes the responsibility for managing the participant's medical care related to the terminal illness. The hospice provides

or arranges for services reasonable and necessary for the palliation or management of the terminal illness and related conditions. This includes all care, supplies, equipment and medicines.

Any provider, other than the attending physician, who provides care related to the terminal illness to a hospice participant, *must* contact the hospice to arrange for payment. MO HealthNet reimburses the hospice provider for covered services and the hospice reimburses the provider of the service(s).

For adults age 21 and over, curative or active treatment of the terminal illness is *not* covered by the MO HealthNet Program while the patient is enrolled with a hospice. If the participant wishes to resume active treatment, they *must* revoke the hospice benefit for MO HealthNet to provide reimbursement of active treatment services. The hospice is reimbursed for the date of revocation. MO HealthNet does *not* provide reimbursement of active treatment until the day following the date of revocation. Children under the age of 21 may continue to receive curative treatment services while enrolled with a hospice.

Services *not* related to the terminal illness are available from any MO HealthNet-participating provider of the participant's choice. Claims for these services should be submitted directly to Wipro Infocrossing.

Refer to the Hospice Manual, Section 13 for a detailed discussion of hospice services.

1.5.E QUALIFIED MEDICARE BENEFICIARIES (QMB)

To be considered a QMB an individual *must*:

- be entitled to Medicare Part A
- have an income of less than 100% of the Federal Poverty Level
- have resources of less than $4000 (or no more than $6000 if married)

Participants who are eligible only as a Qualified Medicare Beneficiary (QMB) are eligible for reimbursement of their Medicare deductible, coinsurance and copay amounts only for Medicare covered services whether or not the services are covered by MO HealthNet. QMB-only participants are *not* eligible for MO HealthNet services that are *not* generally covered by Medicare. When verifying eligibility, QMB-only participants are identified with an ME code 55 when verifying eligibility.

Some participants who are eligible for MO HealthNet covered services under the MO HealthNet or MO HealthNet spenddown categories of assistance may also be eligible as a QMB participant and are identified on the IVR/Internet by a QMB indicator "Y." If the participant has a QMB indicator of "Y" and the ME code is *not* 55 the participant is also

eligible for MO HealthNet services and *not* restricted to the QMB-only providers and services.

QMB coverage includes the services of providers who by choice do *not* participate in the MO HealthNet Program and providers whose services are *not* currently covered by MO HealthNet but who are covered by Medicare, such as chiropractors and independent therapists. Providers who do *not* wish to enroll in the MO HealthNet Program for MO HealthNet participants and providers of Medicare-only covered services may enroll as QMB-only providers to be reimbursed for deductible, coinsurance, and copay amounts only for QMB eligibles. Providers who wish to be identified as QMB-only providers may contact the Provider Enrollment Unit via their e-mail address: mmac.providerenrollment@dss.mo.gov.

Providers who are enrolled with MO HealthNet as QMB-only providers need to ascertain a participant's QMB status in order to receive reimbursement of the deductible and coinsurance and copay amounts for QMB-only covered services.

1.5.F WOMEN'S HEALTH SERVICES PROGRAM (ME CODES 80 and 89)

The Women's Health Services Program provides family planning and family planning-related services to low income women, ages 18 through 55, who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), Medicare, or health insurance that provides family planning services.

Women who have been sterilized are not eligible for the Women's Health Services Program. Women who are sterilized while participating in the Women's Health Services Program become ineligible 90 days from the date of sterilization.

Services for ME codes 80 and 89 are limited to family planning and family planning-related services, and testing and treatment of Sexually Transmitted Diseases (STDs) which are provided in a family planning setting. Services include:

- approved methods of birth control including sterilization and x-ray services related to the sterilization
- family planning counseling and education on birth control options
- testing and treatment for Sexually Transmitted Diseases (STDs)
- pharmacy, including birth control devices & pills, and medication to treat STDs
- Pap Test and Pelvic Exams

All services under the Women's Health Services Program must be billed with a primary diagnosis code within the ranges of Z30.011-Z30.9.

1.5.G TEMP PARTICIPANTS

The purpose of the Temporary MO HealthNet During Pregnancy (TEMP) Program is to provide pregnant women with access to *ambulatory prenatal care* while they await the formal determination of MO HealthNet eligibility. Certain qualified providers, as determined by the Family Support Division, may issue TEMP cards. These providers have the responsibility for making limited eligibility determinations for their patients based on preliminary information that the patient's family income does *not* exceed the applicable MO HealthNet for Pregnant Women income standard for a family of the same size.

If the qualified provider makes an assessment that a pregnant woman is eligible for TEMP, the qualified provider issues her a white paper temporary ID card. The participant may then obtain ambulatory prenatal services from any MO HealthNet-enrolled provider. If the woman makes a formal application for MO HealthNet with the Family Support Division during the period of TEMP eligibility, her TEMP eligibility is extended while the application is pending. If application is *not* made, the TEMP eligibility ends in accordance with the date shown on the TEMP card.

Infants born to mothers who are eligible under the TEMP Program are *not* automatically eligible for MO HealthNet benefits. Information regarding automatic MO HealthNet Eligibility for Newborn Children is addressed in this manual.

Providers and participants can obtain the name of MO HealthNet enrolled Qualified Providers in their service area by contacting the local Family Support Division Call Center at (855) 373-4636. Providers may call Provider Relations at (573) 751-2896 and participants may call Participant Services at (800) 392-2161 for questions regarding TEMP.

1.5.G(1) TEMP ID Card

Pregnant women who have been determined presumptively eligible for Temporary MO HealthNet During Pregnancy (TEMP) do *not* receive a plastic MO HealthNet ID card but receive a white paper TEMP card. A valid TEMP number begins with the letter "P" followed by seven (7) numeric digits. The 8-character temporary number should be entered in the appropriate field of the claim form until a permanent number is issued to the participant. The temporary number appearing on the claim form is converted to the participant's permanent MO HealthNet identification number during claims processing and the permanent number appears on the provider's Remittance Advice. Providers should note the new number and file future claims using the permanent number.

A white paper TEMP card can be issued by qualified providers to *pregnant* women whom they presume to be eligible for MO HealthNet based on income guidelines. A TEMP card is issued for a limited period but presumptive eligibility may be extended if the pregnant woman applies for public assistance at the county Family

Support Division office. The TEMP card may only be used for ambulatory prenatal services. Because TEMP services are limited, providers should verify that the service to be provided is covered by the TEMP card.

The start date (FROM) is the date the qualified provider issues the TEMP card, and coverage expires at midnight on the expiration date (THROUGH) shown. A TEMP replacement letter (IM-29 TEMP) may also be issued when the TEMP individual has formally applied for MO HealthNet and is awaiting eligibility determination.

Third party insurance information does *not* appear on a TEMP card.

1.5.G(2) TEMP Service Restrictions

TEMP services for pregnant women are limited to *ambulatory prenatal services* (physician, clinic, nurse midwife, diagnostic laboratory, x-ray, pharmacy, and outpatient hospital services). Risk Appraisals and Case Management Services are covered under the TEMP Program. Services other than those listed above (i.e. dental, ambulance, home health, durable medical equipment, CRNA, or psychiatric services) may be covered with a Certificate of Medical Necessity in the provider's file that testifies that the pregnancy would have been adversely affected without the service. Proof of medical necessity must be retained in the patient's file and be available upon request by the MO HealthNet Division. Inpatient services, including miscarriage or delivery, are *not* covered for TEMP participants.

Other noncovered services for TEMP participants include; global prenatal care, postpartum care, contraceptive management, dilation and curettage and treatment of spontaneous/missed abortions or other abortions.

1.5.G(3) Full MO HealthNet Eligibility After TEMP

A TEMP participant may apply for full MO HealthNet coverage and be determined eligible for the complete range of MO HealthNet-covered services. Regular MO HealthNet coverage may be backdated and may or may not overlap the entire TEMP eligibility period. Approved participants receive an approval letter that shows their eligibility and type of assistance coverage. These participants also receive an ID card within a few days of approval. The services that are *not* covered under the TEMP Program may be resubmitted under the new type of assistance using the participant's MO HealthNet identification number instead of the TEMP number. The resubmitted claims are then processed without TEMP restrictions for the dates of service that were *not* included under the TEMP period of eligibility.

1.5.H PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Missouri and the Centers for Medicare & Medicaid (CMS) have entered into a three-way program agreement with Alexian Brothers Community Services (ABCS) of St. Louis. PACE is an integrated service system that includes primary care, restorative therapy, transportation, home health care, inpatient acute care, and even long-term care in a nursing facility when home and community-based services are no longer appropriate. Services are provided in the PACE center, the home, or the hospital, depending upon the needs of the individual. Refer to Section 11.11.E.

The target population for this program includes individuals age 55 and older, who are identified by the Missouri Department of Health and Senior Services, Division of Senior Services and Regulation through a health status assessment with specific types of eligibility categories and at least 21 points on the nursing home level of care assessment. These targeted individuals *must* reside in the St. Louis area within specific zip codes. Refer to Section 11.11.A.

Lock-in information is available to providers through the Internet or Interactive Voice Response (IVR). Enrollment in a PACE program is always voluntary and participants have the option to disenroll and return to the fee-for-service system at any time. Refer to Section 11.11.D.

1.5.I MISSOURI'S BREAST AND CERVICAL CANCER TREATMENT (BCCT) ACT

The Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law: 101-354) established the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), to reduce the morbidity and mortality rates of breast and cervical cancers. The NBCCEDP provides grants to states to carry out activities aimed at early screenings and detection of breast and/or cervical cancer, case management services, education and quality assurance. The Missouri Department of Health and Senior Services, Division of Chronic Disease Prevention and Health Promotion's grant application was approved by the Centers for Disease Control and Prevention (CDC) to provide funding to establish the Missouri Breast and Cervical Cancer Control Project (BCCCP), known as Show Me Healthy Women. Matching funds were approved by the Missouri legislation to support breast and cervical cancer screening and education for low-income Missouri women through the Show Me Healthy Women project. Additional federal legislation was signed allowing funded programs in the NBCCEDP to participate in a new program with the MO HealthNet Breast and Cervical Cancer Treatment (BCCT) Act. State legislation authorized matching funds for Missouri to participate.

Most women who are eligible for Show Me Healthy Women, receive a Show Me Healthy Women-paid screening and/or diagnostic service and are found to need treatment for either breast and/or cervical cancer, are eligible for MO HealthNet coverage. For more information,

providers may reference the Show Me Healthy Women Provider Manual at http://www.dhss.mo.gov/BreastCervCancer/providerlist.pdf .

1.5.I(1) Eligibility Criteria

To qualify for MO HealthNet based on the need for BCCT, all of the following eligibility criteria *must* be met:

- Screened by a Missouri BCCCP Provider;
- Need for treatment for breast or cervical cancer including certain pre-cancerous conditions;
- Under the age of 65 years old;
- Have a Social Security Number;
- Citizenship or eligible non-citizen status;
- Uninsured (or have health coverage that does *not* cover breast or cervical cancer treatment);
- A Missouri Resident.

1.5.I(2) Presumptive Eligibility

Presumptive Eligibility (PE) determinations are made by BCCCP MO HealthNet providers. When a BCCCP provider determines a woman is eligible for PE coverage, a BCCT Temporary MO HealthNet Authorization letter is issued and provides for temporary, limited MO HealthNet benefits. A MO HealthNet ID Card is issued and should be received in approximately five days. MO HealthNet coverage under PE begins on the date the BCCCP provider determines the woman is in need of treatment. This allows for minimal delays for women in receiving the necessary treatment. Women receiving coverage under Presumptive Eligibility are assigned ME code 83. PE coverage continues until the last day of the month that the regular MO HealthNet application is approved or BCCT is no longer required, whichever is later.

1.5.I(3) Regular BCCT MO HealthNet

The BCCT MO HealthNet Application *must* be completed by the PE eligible client and forwarded as soon as possible to a managed care Service Center or the local Family Support Division office to determine eligibility for regular BCCT MO HealthNet benefits. The PE eligible client receives information from MO HealthNet for the specific services covered. Limited MO HealthNet benefits coverage under regular BCCT begins the first day of the month of application, if the woman meets all eligibility requirements. Prior quarter coverage can also be

approved, if the woman was eligible. Coverage *cannot* begin prior to the month the BCCCP screening occurred. No coverage can begin prior to August 28, 2001 (although the qualifying screening may have occurred prior to August 28, 2001). MO HealthNet benefits are discontinued when the treating physician determines the client no longer needs treatment for the diagnosed condition or if MO HealthNet denies the BCCT application. Women approved for Regular BCCT MO HealthNet benefits are assigned ME code 84.

1.5.I(4) Termination of Coverage

MO HealthNet coverage is date-specific for BCCT cases. A date-specific termination can take effect in the future, up to the last day of the month following the month of the closing action.

1.5.J TICKET TO WORK HEALTH ASSURANCE PROGRAM

Implemented August 28, 2007, the Ticket to Work Health Assurance Program (TWHAP) eligibility groups were authorized by the federal Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) and Missouri Senate Bill 577 (2007). TWHAP is for individuals who have earnings and are determined to be permanently and totally disabled or would be except for earnings. They have the same MO HealthNet fee-for-service benefits package and cost sharing as the Medical Assistance for the Permanently and Totally Disabled (ME code 13). An age limitation, 16 through 64, applies. The gross income ceiling for this program is 300% of the Federal Poverty Level (FPL) for an individual or a Couple. Premiums are charged on a sliding scale based on gross income between 101% - 300% FPL. Additional income and asset disregards apply for MO HealthNet. Proof of employment/self-employment is required. Eligible individuals are enrolled with ME code 85 for premium and ME code 86 for non-premium. Eligibility for the Ticket to Work Health Assurance Program is determined by the Family Support Division.

1.5.J(1) Disability

An individual must meet the definition of Permanent and Total Disability. The definition is the same as for Medical Assistance (MA), except earnings of the individual are not considered in the disability determination.

1.5.J(2) Employment

An individual and/or spouse must have earnings from employment or self-employment. There is no minimum level of employment or earnings required. The maximum is gross income allowed is 250% of the federal poverty level, excluding any earned income of the worker with a disability between 250 and 300% of the federal poverty level. "Gross income" includes all income of the person and the

person's spouse. Individuals with gross incomes in excess of 100% of the federal poverty level shall pay a premium for participation.

1.5.J(3) Premium Payment and Collection Process

An individual whose computed gross income exceeds 100%, but is not more than 300%, of the FPL must pay a monthly premium to participate in TWHAP. TWHAP premium amounts are based on a formula specified by State statute. On new approvals, individuals in the premium group must select the beginning date of coverage, which may be as early as the first month of the prior quarter (if otherwise applicable) but no later than the month following approval. If an individual is not in the premium group, coverage begins on the first day of the first month the client is eligible.

Upon approval by Family Support Division, the MO HealthNet Division (MHD) sends an initial Invoice letter, billing the individual for the premium amount for any past coverage selected through the month following approval. Coverage does not begin until the premium payment is received. If the individual does not send in the complete amount, the individual is credited for any full month premium amount received starting with the month after approval and going back as far as the amount of paid premium allows.

Thereafter, MHD sends a Recurring Invoice on the second working day of each month for the next month's premium. If the premium is not received prior to the beginning of the new month, the individual's coverage ends on the day of the last paid month.

MHD sends a Final Recurring Invoice after the individual has not paid for three consecutive months. It is sent in place of the Recurring Invoice, on the second working day of the month for the next month's premium. The Final Recurring Invoice notifies the individual that the case will be closed if a payment is not received by the end of the month.

MHD collects the premiums as they do for the Medical Assistance (MA) Spenddown Program and the managed care program.

1.5.J(4) Termination of Coverage

MO HealthNet coverage end dates are the same as for the Medical Assistance Program. TWHAP non-premium case end dates are date-specific. TWHAP premium case end dates are not date-specific.

1.5.K PRESUMPTIVE ELIGIBILITY FOR CHILDREN

The Balanced Budget Act of 1997 (The Act) created Section 1920A of the Social Security Act which gives states the option of providing a period of presumptive eligibility to children when a qualified entity determines their family income is below the state's applicable MO HealthNet or SCHIP limit. This allows these children to receive medical care before they have formally applied for MO HealthNet for Kids. Missouri selected this option and effective March 10, 2003, children under the age of 19 may be determined eligible for benefits on a temporary basis prior to having a formal eligibility determination completed.

Presumptive eligible children are identified by ME code 87. These children receive the full range of MO HealthNet for Kids covered services subject to the benefits and limitations specified in each MO HealthNet provider manual. These children are *NOT* enrolled in managed care health plans but receive all services on a fee-for-service basis as long as they are eligible under ME code 87.

1.5.K(1) Eligibility Determination

The Act allows states to determine what type of Qualified Entities to use for Presumptive Eligibility determinations. Currently, Missouri is limiting qualified entities to children's hospitals. Designated staff of qualified entities makes Presumptive Eligibility determinations for children by determining the family meets the income guidelines and contacting the MO HealthNet for Kids Phone Centers to obtain a MO HealthNet number. The family is then provided with a MO HealthNet Presumptive Eligibility Authorization (PC-2) notice that includes the MO HealthNet number and effective date of coverage. This notice guarantees a minimum of five days of coverage with day one being the beginning date. After the five days, providers *must* check eligibility as for any client. Coverage for each child under ME code 87 continues until the last day of the second month of Presumptive Eligibility, unless the Family Support Division determines eligibility or ineligibility for MO HealthNet for Kids prior to that day. Presumptive Eligibility coverage ends on the date the child is approved or rejected for a regular MO HealthNet Program. Presumptive Eligibility is limited to one period during a rolling 12 month period.

Qualified entities making temporary eligibility determinations for children facilitate a formal application for MO HealthNet for Kids. Children who are then determined by the Family Support Division to be eligible for MO HealthNet for Kids are placed in the appropriate MO HealthNet eligibility category (ME code), and are subsequently enrolled with a MO HealthNet Managed Care health plan if residing in a managed care health plan area and under ME codes enrolled with managed care health plans.

1.5.K(2) MO HealthNet for Kids Coverage

Children determined presumptively eligible for MO HealthNet for Kids receive the same coverage during the presumptive period. The children active under Presumptive Eligibility for Children are *not* enrolled in managed care. While the children *must* obtain their presumptive determination from a Qualified Entity (QE), once eligible, they can obtain covered services from any enrolled MO HealthNet fee-for-service provider. Coverage begins on the date the QE makes the presumptive eligibility determination and coverage ends on the later of:

- the 5th day after the Presumptive Eligibility for Children determination date;
- the day a MO HealthNet for Kids application is approved or rejected; or
- if no MO HealthNet for Kids application is made, the last date of the month following the month of the presumptive eligibility determination.

A presumptive eligibility period has no effect on the beginning eligibility date of regular MO HealthNet for Kids coverage. Prior quarter coverage may be approved. In many cases the MO HealthNet for Kids begin dates may be prior to the begin date of the presumptive eligibility period.

1.5.L MO HEALTHNET COVERAGE FOR INMATES OF A PUBLIC INSTITUTION

Changes to eligibility requirements may allow incarcerated individuals (both juveniles and adults), who leave the public institution to enter a medical institution or individuals who are under house arrest, to be determined eligible for temporary MO HealthNet coverage. Admittance as an inpatient in a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility interrupts or terminates the inmate status. Upon an inmate's admittance, the Family Support Division office in the county in which the penal institution is located may take the appropriate type of application for MO HealthNet benefits. The individual, a relative, an authorized representative, or penal institution designee may initiate the application.

When determining eligibility for these individuals, the county Family Support Division office considers all specific eligibility groups, including children, pregnant women, and elderly, blind or disabled, to determine if the individual meets all eligibility factors of the program for which they are qualifying. Although confined to a public institution, these individuals may have income and resources available to them. If an individual is ineligible for MO HealthNet, the application is rejected immediately and the appropriate rejection notice is sent to the individual.

MO HealthNet eligibility is limited to the days in which the individual was an inpatient in the medical institution. Once the individual returns to the penal institution, the county Family Support Division office verifies the actual inpatient dates in the medical institution and determines the period of MO HealthNet eligibility. Appropriate notification is sent to the individual. The approval notice includes the individual's specific eligibility dates and a statement that they are *not* currently eligible for MO HealthNet because of their status as an inmate in a public institution.

Some individuals may require admittance into a long term care facility. If determined eligible, the period of MO HealthNet eligibility is based on the length of inpatient stay in the long term care facility. Appropriate MO HealthNet eligibility notification is sent to the individual.

1.5.L(1) MO HealthNet Coverage Not Available

Eligibility for MO HealthNet coverage does *not* exist when the individual is an inmate and when the facility in which the individual is residing is a public institution. An individual is an inmate when serving time for a criminal offense or confined involuntarily to a state or federal prison, jail, detention facility or other penal facility. An individual voluntarily residing in a public institution is *not* an inmate. A facility is a public institution when it is under the responsibility of a government unit, or a government unit exercises administrative control over the facility.

MO HealthNet coverage is *not* available for individuals in the following situations:

- Individuals (including juveniles) who are being held involuntarily in detention centers awaiting trial;
- Inmates involuntarily residing at a wilderness camp under governmental control;
- Inmates involuntarily residing in half-way houses under governmental control;
- Inmates receiving care on the premises of a prison, jail, detention center, or other penal setting; or
- Inmates treated as outpatients in medical institutions, clinics or physician offices.

1.5.L(2) MO HealthNet Benefits

If determined eligible by the county Family Support Division office, full or limited MO HealthNet benefits may be available to individuals residing in or under the control of a penal institution in any of the following circumstances:

- Infants living with the inmate in the public institution;
- Paroled individuals;
- Individuals on probation;
- Individuals on home release (except when reporting to a public institution for overnight stay); or
- Individuals living voluntarily in a detention center, jail or county penal facility after their case has been adjudicated and other living arrangements are being made for them (for example, transfer to a community residence).

All specific eligibility groups, including children, pregnant women, and elderly, blind or disabled are considered to determine if the individual meets all eligibility factors of the program for which they are applying.

1.5.M VOLUNTARY PLACEMENT AGREEMENT, OUT-OF- HOME CHILDREN'S SERVICES

With the 2004 passage of House Bill 1453, the Voluntary Placement Agreement (VPA) was introduced and established in statute. The VPA is predicated upon the belief that no parent should have to relinquish custody of a child solely in order to access clinically indicated mental health services. This is a written agreement between the Department of Social Services (DSS)/Children's Division (CD) and a parent, legal guardian, or custodian of a child under the age of eighteen (18) solely in need of mental health treatment. A VPA developed pursuant to a Department of Mental Health (DMH) assessment and certification of appropriateness authorizes the DSS/CD to administer the placement and out-of-home care for a child while the parent, legal guardian, or custodian of the child retains legal custody. The VPA requires the commitment of a parent to be an active participant in his/her child's treatment

1.5.M(1) Duration of Voluntary Placement Agreement

The duration of the VPA may be for as short a period as the parties agree is in the best interests of the child, but under no circumstances shall the total period of time that a child remains in care under a VPA exceed 180 days. Subsequent agreements may be entered into, but the total period of placement under a single VPA or series of VPAs shall *not* exceed 180 days without express authorization of the Director of the Children's Division or his/her designee.

1.5.M(2) Covered Treatment and Medical Services

Children determined eligible for out-of-home care, (ME88), per a signed VPA, are eligible for a variety of children's treatment services, medical and psychiatric

services. The CD worker makes the appropriate referrals to CD approved contractual treatment providers. Payment is made at the MO HealthNet or state contracted rates. Providers should contact the local CD staff for payment information.

1.5.M(3) Medical Planning for Out-of-Home Care

Medical planning for children in out-of-home care is a necessary service to ensure that children receive the needed medical care. The following includes several medical service alternatives for which planning is necessary:

- Routine Medical/Dental Care;
- Human Immunodeficiency Virus (HIV) Screening;
- Emergency and Extraordinary Medical/Dental Care (over $500.00);
- Children's Treatment Services;
- Medical/Dental Services Program;
- Bureau for Children with Special Health Care Needs;
- Department of Mental Health Services;
- Residential Care;
- Private Psychiatric Hospital Placement; or
- Medical Foster Care.

1.6 ELIGIBILITY PERIODS FOR MO HEALTHNET PARTICIPANTS

Most participants are eligible for coverage of their services on a fee-for-service basis for those retroactive periods of eligibility from the first of the month of application until approval, or until the effective date of their enrollment in a MO HealthNet managed care health plan. This is often referred to as the period of "backdated eligibility."

Eligibility for MO HealthNet participants (except ME codes 71, 72, 73, 74, 75 and 89) is from the first day of the month of application through the last day of each subsequent month for which they are eligible unless the individual is subject to the provisions of Day Specific Eligibility. Some MO HealthNet participants may also request and be approved for prior quarter coverage.

Participants with ME codes 71, 72 and 89 are eligible for MO HealthNet benefits from the first day of the month of application and are subject to the provisions of Day Specific Eligibility. Codes 71 and 72 are eligible from date of application. ME Code 80 is Extended Women's Health Care and eligibility begins the beginning of the month following the 60 day post partum coverage period for MPW (if *not* insured).

MO HealthNet for Kids participants with ME codes 73, 74, and 75 who *must* pay a premium for coverage are eligible the later of 30 days after the date of application or the date the premium is paid. The 30 day waiting period does *not* apply to children with special health care needs. Codes 73 and 74 are eligible on the date of application or date premium is paid, whichever is later. Code 75 is eligible for coverage the later of 30 days after date of application or date premium is paid. All three codes are subject to day specific eligibility (coverage ends date case/eligibility is closed).

MO HealthNet participants with ME code 83 are eligible for coverage beginning on the day the BCCCP provider determines the woman is in need of treatment for breast or cervical cancer. Presumptive Eligibility coverage continues until the last day of the month that the regular MO HealthNet application is approved or BCCT is no longer required, whichever is last.

MO HealthNet participants with ME code 84 are eligible for coverage beginning the 1st day of the month of application. Prior quarter coverage may also be approved, if the woman is eligible. Coverage *cannot* begin prior to the month the BCCCP screening occurred. No coverage can begin prior to August 28, 2001.

MO HealthNet children with ME code 87 are eligible for coverage during the presumptive period (fee-for-service only). Coverage begins on the date of the presumptive eligibility determination and ends on the later of 5th day after the eligibility determination or the day a MO HealthNet for Kids application is approved or rejected or if no MO HealthNet for Kids application is made, the last day of the month following the month of the presumptive eligibility determination.

For those participants who reside in a MO HealthNet managed care county and are approved for a category of assistance included in MO HealthNet managed care, the reimbursement is fee-for-service or covered services for the period from the date of eligibility until enrollment in a managed care health plan. Once a participant has been notified they are eligible for assistance, they have 15 days to select a managed care health plan or have a managed care health plan assigned for them. After they have selected the managed care health plan, they are *not* actually enrolled in the managed care health plan for another 15 days.

The ID Card is mailed out within a few days of the caseworker's eligibility approval. Participants may begin to use the ID Card when it is received. Providers should honor the approval/replacement/case action letter until a new card is received. MO HealthNet and managed care participants should begin using their new ID Card when it is received.

1.6.A DAY SPECIFIC ELIGIBILITY

Certain MO HealthNet participants are subject to the provisions of Day Specific Eligibility. This means that some MO HealthNet participants lose eligibility at the time of case closure, which may occur anytime in the month. Prior to implementation of Day Specific Eligibility, participants in all categories of assistance retained eligibility through the last date of the

month if they were eligible on the first of the month. As of January 1, 1997, this varies for certain MO HealthNet participants.

As with all MO HealthNet services, the participant *must* be eligible on the date of service. When the participant is in a Day Specific Eligibility category of assistance, the provider is *not* able to check eligibility on the Internet or IVR for a future date during the current month of eligibility.

In order to convey to a provider that a participant's eligibility is day specific, the MO HealthNet Division provides a verbal message on the IVR system. The Internet also advises of day specific eligibility.

Immediately following the current statement, "The participant is eligible for service on MONTH, DAY, YEAR through MONTH, DAY, YEAR with a medical eligibility code of XX," the IVR says, "This participant is subject to day specific eligibility." The Internet gives this information in the same way as the IVR.

If neither the Internet nor IVR contains a message that the participant is subject to day specific eligibility, the participant's eligibility continues through the last day of the current month. Providers are able to check eligibility for future dates for the participants who are *not* subject to day specific eligibility.

It is important to note that the message regarding day specific eligibility is only a reminder to providers that the participant's type of assistance is such that should his/her eligibility end, it may be at any time during that month. The Internet and IVR will verify the participant's eligibility in the usual manner.

Providers *must* also continue to check for managed care health plan enrollment for those participant's whose ME codes and county are included in managed care health plan enrollment areas, because participant's enrollment or end dates can occur any date within the month.

1.6.B SPENDDOWN

In the MO HealthNet for the Aged, Blind, and Disabled (MHABD) Program some individuals are eligible for MO HealthNet benefits only on the basis of meeting a periodic spenddown requirement. Effective October 1, 2002, eligibility for MHABD spenddown is computed on a monthly basis. If the individual is eligible for MHABD on a spenddown basis, MO HealthNet coverage for the month begins with the date on which the spenddown is met and ends on the last day of that month when using medical expenses to meet spenddown. MO HealthNet coverage begins and ends without the case closing at the end of the monthly spenddown period. The MO HealthNet system prevents payment of medical services used to meet an individual's spenddown amount.

The individual may choose to meet their spenddown by one of the following options:

- submitting incurred medical expenses to their Family Support Division (FSD) Eligibility Specialist; or
- paying the monthly spenddown amount to the MO HealthNet Division (MHD).

Effective July 1, 2012, a participant can meet spenddown by using a combination of incurred expenses and paying the balance to MHD.

Individuals have the option of changing the method in which their spenddown is met each month. A choice is made to either send the payment to MHD or to send bills to the FSD Eligibility Specialist. For those months that the individual does *not* pay-in or submit bills, no coverage is available.

1.6.B(1) Notification of Spenddown Amount

MHD mails a monthly invoice to active spenddown cases on the second working day of each month. The invoice is for the next month's spenddown amount. The invoice gives the participant the option of paying in the spenddown amount to MHD or submitting bills to FSD. The invoice instructs the participant to call the MHD Premium Collections Unit at 1 (877) 888-2811 for questions about a payment.

MHD stops mailing monthly invoices if the participant does *not* meet the spenddown for 6 consecutive months. MHD resumes mailing invoices the month following the month in which the participant meets spenddown by bills or pay-in for the current month or past months.

1.6.B(2) Notification of Spenddown on New Approvals

On new approvals, the FSD Eligibility Specialist *must* send an approval letter notifying the participant of approval for spenddown, but MO HealthNet coverage does *not* begin until the spenddown is met. The letter informs the participant of the spenddown amount and the months for which coverage may be available once spenddown is met. If the Eligibility Specialist has already received bills to meet spenddown for some of the months, the letter includes the dates of coverage for those months.

MHD sends separate invoices for the month of approval and the month following approval. These invoices are sent on the day after the approval decision. Notification of the spenddown amount for the months prior to approval is only sent by the FSD Eligibility Specialist.

1.6.B(3) Meeting Spenddown with Incurred and/or Paid Expenses

If the participant chooses to meet spenddown for the current month using incurred and/or medical expenses, MO HealthNet coverage begins on the date the incurred and/or expenses equal the spenddown amount. The bills do *not* have to have been paid. In order to determine whether or not the participant has met spenddown, the FSD Eligibility Specialist counts the full amount of the valid medical expenses the participant incurred and/or paid to establish eligibility for spenddown coverage. The Eligibility Specialist does *not* try to estimate amounts, or deduct estimated amounts, to be paid by the participant's insurance from the amount of incurred and/or paid expenses. The QMB Program provides MO HealthNet payment of the Medicare premium, and coinsurance, deductibles and copay for all Medicare covered services. Therefore, the cost of Medicare covered services *cannot* be used to meet spenddown for participants approved for QMB.

Upon receipt of verification that spenddown has been met with incurred and/or paid expenses for a month, FSD sends a Notification of Spenddown Coverage letter to inform the participant spenddown was met with the incurred and/or paid expenses. The letter informs the participant of the MO HealthNet start date and the amount of spenddown met on the start date.

1.6.B(4) Meeting Spenddown with a Combination of Incurred Expenses and Paying the Balance

If the participant chooses to meet spenddown for a month using incurred expenses and paying the balance of their spenddown amount, coverage begins on the date of the most recent incurred expense once the balance is paid and received by MHD. The participant must take the incurred expenses to their FSD Eligibility Specialist who will inform them of the balance they must pay to MHD.

1.6.B(5) Preventing MO HealthNet Payment of Expenses Used to Meet Spenddown

On spenddown cases, MO HealthNet only reimburses providers for covered medical expenses that exceed a participant's spenddown amount. MO HealthNet does *not* pay the portion of a bill used to meet the spenddown. To prevent MO HealthNet from paying for an expense used to meet spenddown, MHD withholds the participant liability amount of spenddown met on the first day of coverage for a month. The MHD system tracks the bills received for the first day of coverage until the bills equal the participant's remaining spenddown liability. For the first day of coverage, MHD denies or splits (partially pays) the claims until the participant's liability for that first day is reduced to zero. After MHD has reduced the liability to

zero for the first day of coverage, other claims submitted for that day of spenddown coverage are paid up to the MO HealthNet rate. Claims for all other days of spenddown coverage process in the same manner as those of non-spenddown participants. MHD notifies both the provider and the participant of any claim amount *not* paid due to the bill having been used to meet spenddown.

When a participant has multiple expenses on the day spenddown is met and the total expenses exceed the remaining spenddown, the liability amount may be withheld from the wrong claim. This can occur if Provider A submits a claim to MHD and Provider B does *not* (either because the bill was paid or it was a non-MO HealthNet covered service). Since the MHD system can only withhold the participant liability from claims submitted, the liability amount is deducted from the bill of the Provider A. Provider B's bill may have been enough to reduce the liability to zero, which would have allowed MO HealthNet to pay for Provider A's claim. MHD Participants Services Unit authorizes payment of the submitted claim upon receipt of verification of other expenses for the day which reduced the liability to zero. The Participant Services Unit may request documentation from the case record of bills FSD used to meet spenddown on the day it was met.

1.6.B(6) Spenddown Pay-In Option

The pay-in option allows participants to meet spenddown requirements by making a monthly payment of the spenddown amount to MHD. Participants who choose to pay-in may pay by sending a check (or money order) each month to MHD or having the spenddown amount automatically withdrawn from a bank account each month. When a participant pays in, MHD creates a coverage period that begins on the first day of the month for which the participant is paying. If the participant pays for the next month prior to the end of the current month, there is no end date on the coverage period. If a payment has been missed, the coverage period is *not* continuous.

Participants are given the option of having the spenddown amount withdrawn from an existing bank account. Withdrawals are made on the 10th of each month for the following month's coverage. The participant receives a monthly notification of withdrawal from MHD.

In some instances, other state agencies, such as Department of Mental Health, may choose to pay the spenddown amount for some of their clients. Agencies interested in this process work with MHD to identify clients the agency intends to pay for and establish payment options on behalf of the client.

1.6.B(7) Prior Quarter Coverage

The eligibility determination for prior quarter MO HealthNet coverage is separate from the eligibility determination for current MO HealthNet coverage. A participant does *not* have to be currently eligible for MO HealthNet coverage to be eligible for prior quarter coverage. Prior quarter coverage can begin no earlier than the first day of the third month prior to the month of the application and can extend up to but *not* including the first day of the month of application. The participant *must* meet all eligibility requirements including spenddown/non-spenddown during the prior quarter. If the participant becomes eligible for assistance sometime during the prior quarter, the date on which eligibility begins depends on whether the participant is eligible as a non-spenddown or spenddown case.

MO HealthNet coverage begins on the first day in which spenddown is met in each of the prior months. Each of the three prior quarter month's medical expenses are compared to that month's spenddown separately. Using this process, it may be that the individual is eligible for one, two or all three months, sometimes *not* consecutively. As soon as the FSD Eligibility Specialist receives bills to meet spenddown for a prior quarter month, eligibility is met.

1.6.B(8) MO HealthNet Coverage End Dates

MO HealthNet coverage is date-specific for MO HealthNet for the Aged, Blind, and Disabled (MHABD) non-spenddown cases at the time of closing. A date-specific closing can take effect in the future, up to the last day of the month following the month of closing. For MHABD spenddown cases MO HealthNet eligibility and coverage is *not* date-specific at the time of the closing. When an MHABD spenddown case is closed, MO HealthNet eligibility continues through the last day of the month of the closing. If MO HealthNet coverage has been authorized by pay-in or due to incurred expenses, it continues through the last day of the month of the closing.

1.6.C PRIOR QUARTER COVERAGE

Eligibility determination for prior quarter Title XIX coverage is separate from the eligibility determination of current Title XIX coverage. An individual does *not* have to be currently eligible for Title XIX coverage to be eligible for prior quarter coverage and vice versa.

Eligible individuals may receive Title XIX coverage retroactively for up to 3 months prior to the month of application. This 3-month period is referred to as the prior quarter. The effective date of prior quarter coverage for participants can be no earlier than the first day of the third month prior to the month of the application and can extend up to, but *not* include, the first day of the month of application.

MO HealthNet for Kids (ME codes 71-75) who meet federal poverty limit guidelines and who qualify for coverage because of lack of medical insurance are *not* eligible to receive prior quarter coverage.

The individual *must* have met all eligibility factors during the prior quarter. If the individual becomes eligible for assistance sometime during the prior quarter, eligibility for Title XIX begins on the first day of the month in which the individual became eligible or, if a spenddown case, the *date* in the prior 3-month period on which the spenddown amount was equaled or exceeded.

Example of Prior Quarter Eligibility on a Non-Spenddown Case: An individual applies for assistance in June. The prior quarter is March through May. A review of the eligibility requirements during the prior quarter indicates the individual would have been eligible on March 1 because of depletion of resources. Title XIX coverage begins March 1 and extends through May 31 if an individual continues to be eligible during April and May.

1.6.D EMERGENCY MEDICAL CARE FOR INELIGIBLE ALIENS

The Social Security Act provides MO HealthNet coverage for emergency medical care for ineligible aliens, who meet all eligibility requirements for a federally funded MO HealthNet program except citizenship/alien status. *Coverage is for the specific emergency only*. Providers should contact the local Family Support Division office and identify the services and the nature of the emergency. State staff identify the emergency nature of the claim and add or deny coverage for the period of the emergency only. Claims are reimbursed only for the eligibility period identified on the participant's eligibility file. An emergency medical condition is defined as follows:

An emergency medical condition for a MO HealthNet participant means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) there is no adequate time to affect a safe transfer to another hospital before delivery; or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

1.7 PARTICIPANT ELIGIBILITY LETTERS AND CLAIMS CORRESPONDENCE

It is common for MO HealthNet participants to be issued an eligibility letter from the Family Support Division or other authorizing entity that may be used in place of an ID card. Participants who are new approvals or who need a replacement card are given an authorization letter. These letters are valid proof of eligibility in lieu of an ID Card. Dates of eligibility and most restrictions are contained in these letters. Participants who are enrolled or who will be enrolled in a managed care health plan may *not* have this designation identified on the letter. It is important that the provider verify the managed care enrollment status for participants who reside in a managed care service area. If the participant does *not* have an ID Card or authorization letter, the provider may also verify eligibility by contacting the IVR or the Internet if the participant's MO HealthNet number is known. Refer to Section 3.3.A

The MO HealthNet Division furnishes MO HealthNet participants with written correspondence regarding medical services submitted as claims to the division. Participants are also informed when a prior authorization request for services has been made on their behalf but denied.

1.7.A NEW APPROVAL LETTER

An Approval Notice (IM-32, IM-32 MAF, IM-32 MC, IM-32 MPW or IM-32 PRM, IM-32 QMB) is prepared when the application is approved. Coverage may be from the first day of the month of application or the date of eligibility in the prior quarter until the last day of the month in which the case was approved or the last day of the following month if approval occurs late in the month. Approval letters may be used to verify eligibility for services until the ID Card is received. The letter indicates whether an individual will be enrolled with a MO HealthNet managed care health plan. It also states whether the individual is required to pay a copay for certain services. Each letter is slightly different in content.

Spenddown eligibility letters cover the date spenddown is met until the end of the month in which the case was approved. The eligibility letters contain Yes/No boxes to indicate Lock-In, Hospice or QMB. If the "Yes" box is checked, the restrictions apply.

1.7.A(1) Eligibility Letter for Reinstated TANF (ME 81) Individuals

Reinstated Temporary MO HealthNet for Needy Families (TMNF) individuals have received a letter from the Family Support Division that serves as notification

of temporary medical eligibility. They may use this letter to contact providers to access services.

1.7.A(2) BCCT Temporary MO HealthNet Authorization Letter

Presumptive Eligibility (PE) determinations are made by Breast and Cervical Cancer Control Project (BCCCP) MO HealthNet providers. When a BCCCP provider determines a woman is eligible for PE coverage, a BCCT Temporary MO HealthNet Authorization letter is issued which provides for temporary, full MO HealthNet benefits. A MO HealthNet ID Card is issued and should be received in approximately five days. MO HealthNet coverage under PE begins on the date the BCCCP provider determines the woman is in need of treatment.

1.7.A(3) Presumptive Eligibility for Children Authorization PC-2 Notice

Eligibility determinations for Presumptive Eligibility for Children are limited to qualified entities approved by the state. Currently only children's hospitals are approved. Upon determination of eligibility, the family is provided with a Presumptive Eligibility Authorization (PC-2) notice that includes the MO HealthNet number and effective date of coverage. This notice guarantees a minimum of five days of coverage with day one being the beginning date. After the five days, providers should be checking eligibility as for any client.

1.7.B REPLACEMENT LETTER

A participant may also have a replacement letter, which is the MO HealthNet Eligibility Authorization (IM-29, IM-29 QMB and IM-29 TEMP), from the Family Support Division county office as proof of MO HealthNet eligibility in lieu of a MO HealthNet ID card. This letter is issued when a card has been lost or destroyed.

There are check-off boxes on the letter to indicate if the letter is replacing a lost card or letter. A provider should use this letter to verify eligibility as they would the ID Card. Participants who live in a managed care service area may *not* have their managed care health plan identified on the letter. Providers need to contact the IVR or the Internet to verify the managed care health plan enrollment status.

A replacement letter is only prepared upon the request of the participant.

1.7.C NOTICE OF CASE ACTION

A Notice of Case Action (IM-33) advises the participant of application rejections, case closings, changes in the amount of cash grant, or ineligibility status for MO HealthNet benefits resulting from changes in the participant’s situation. This form also advises the

participant of individuals being added to a case and authorizes MO HealthNet coverage for individuals being added.

1.7.D PARTICIPANT EXPLANATION OF MO HEALTHNET BENEFITS

The MO HealthNet Division randomly selects 300 MO HealthNet participants per month to receive a Participant Explanation of MO HealthNet Benefits (PEOMB) for services billed or managed care health plan encounters reported. The PEOMB contains the following information:

- Date the service was provided;
- Name of the provider;
- Description of service or drug that was billed or the encounter reported; and
- Information regarding how the participant may contact the Participant Services Unit by toll-free telephone number and by written correspondence.

The PEOMB sent to the participant clearly indicates that it is *not* a bill and that it does *not* change the participant's MO HealthNet benefits.

The PEOMB does *not* report the capitation payment made to the managed care health plan in the participant's behalf.

1.7.E PRIOR AUTHORIZATION REQUEST DENIAL

When the MO HealthNet Division *must* deny a Prior Authorization Request for a service that is delivered on a fee-for-service basis, a letter is sent to the participant explaining the reason for the denial. The most common reasons for denial are:

- Prior Authorization Request was returned to the provider for corrections or additional information.
- Service or item requested does *not* require prior authorization.
- Authorization has been granted to another provider for the same service or item.
- Our records indicate this service has already been provided.
- Service or item requested is *not* medically necessary.

The Prior Authorization Request Denial letter gives the address and telephone number that the participant may call or write to if they feel the MO HealthNet Division was wrong in denying the Prior Authorization Request. The participant *must* contact the MO HealthNet Division, Participant Services Unit, within 90 days of the date on the letter, if they want the denial to be reviewed.

Participants enrolled in a managed care health plan do *not* receive the Prior Authorization Request Denial letter from the MO HealthNet Division. They receive notification from the managed care health plan and can appeal the decision from the managed care health plan. The participant's member handbook tells them how to file a grievance or an appeal.

1.7.F PARTICIPANT SERVICES UNIT ADDRESS AND TELEPHONE NUMBER

A participant may send written correspondence to:

Participant Services Agent
P.O. Box 3535
Jefferson City, MO 65102

The participant may also call the Participant Services Unit at (800) 392-2161 toll free, or (573) 751-6527. Providers should *not* call the Participant Services Unit unless a call is requested by the state.

1.8 TRANSPLANT PROGRAM

The MO HealthNet Program provides limited coverage and reimbursement for the transplantation of human organs or bone marrow/stem cell and related medical services. Current policy and procedure is administered by the MO HealthNet Division with the assistance of its Transplant Advisory Committee.

1.8.A COVERED ORGAN AND BONE MARROW/STEM CELL TRANSPLANTS

With prior authorization from the MO HealthNet Division, transplants may be provided by MO HealthNet approved transplant facilities for transplantation of the following:

- Bone Marrow/Stem Cell
- Heart
- Kidney
- Liver
- Lung
- Small Bowel
- Multiple organ transplants involving a covered transplant

1.8.B PATIENT SELECTION CRITERIA

The transplant prior authorization process requires the transplant facility or transplant surgeon to submit documentation that verifies the transplant candidate has been evaluated according to the facility's Patient Selection Protocol and Patient Selection Criteria for the

type of transplant to be performed. The patient *must* have been accepted as a transplant candidate by the facility before prior authorization requests can be considered for approval by the MO HealthNet Division.

Bone Marrow/Stem Cell transplant candidates *must* also meet the general diagnosis and donor guidelines established by the Bone Marrow/Stem Cell Transplant Advisory Committee.

All transplant requests for authorization are reviewed on a case-by-case basis. If the request is approved, an agreement is issued to the transplant facility that *must* be signed and returned to the MO HealthNet Division.

1.8.C CORNEAL TRANSPLANTS

Corneal transplants are covered for eligible MO HealthNet participants and do *not* require prior authorization. Corneal transplants have certain restrictions that are discussed in the physician and hospital manuals.

1.8.D ELIGIBILITY REQUIREMENTS

For the transplant facility or related service providers to be reimbursed by MO HealthNet, the transplant patient *must* be eligible for MO HealthNet on each date of service. A participant *must* have an ID card or eligibility letter to receive MO HealthNet benefits.

Human organ and bone marrow/stem cell transplant coverage is restricted to those participants who are eligible for MO HealthNet. Transplant coverage is *NOT* available for participants who are eligible under a state funded MO HealthNet ME code. (See Section 1.1).

Individuals whose type of assistance does *not* cover transplants should be referred to their local Family Support Division office to request application under a type of assistance that covers transplants. In this instance the MO HealthNet Division Transplant Unit should be advised immediately. The MO HealthNet Division Transplant Unit works with the Family Support Division to expedite the application process.

1.8.E MANAGED CARE PARTICIPANTS

Managed care members receive a transplant as a fee-for-service benefit reimbursed by the MO HealthNet Division. The transplant candidate is allowed freedom of choice of Approved MO HealthNet Transplant Facilities

The transplant surgery, from the date of the transplant through the date of discharge or significant change in diagnosis not related to the transplant surgery and related transplant services (procurement, physician, lab services, etc.) are *not* the managed care health plan's responsibility. The transplant procedure is prior authorized by the MO HealthNet Division.

Claims for the pre-transplant assessment and care are the responsibility of the managed care health plan and *must* be authorized by the MO HealthNet managed care health plan.

Any outpatient, inpatient, physician and related support services rendered prior to the date of the actual transplant surgery *must* be authorized by the managed care health plan and are the responsibility of the managed care health plan.

The managed care health plan is responsible for post-transplant follow-up care. In order to assure continuity of care, follow-up services *must* be authorized by the managed care health plan. Reimbursement for those authorized services is made by the managed care health plan. Reimbursement to non-health plan providers *must* be no less than the current MO HealthNet FFS rate.

The MO HealthNet Division only reimburses providers for those charges directly related to the transplant including the organ or bone marrow/stem cell procurement costs, actual inpatient transplant surgery costs, post-surgery inpatient hospital costs associated with the transplant surgery, and the transplant physicians' charges and other physicians' services associated with the patient's transplant.

1.8.F MEDICARE COVERED TRANSPLANTS

Kidney, heart, lung, liver and certain bone marrow/stem cell transplants are covered by Medicare. If the patient has both Medicare and MO HealthNet coverage and the transplant is covered by Medicare, the Medicare Program is the first source of payment. In this case the requirements or restrictions imposed by Medicare apply and MO HealthNet reimbursement is limited to applicable deductible and coinsurance amounts.

Medicare restricts coverage of heart, lung and liver transplants to Medicare-approved facilities. In Missouri, St. Louis University Hospital, Barnes-Jewish Hospital in St. Louis, St. Luke's Hospital in Kansas City, and the University of Missouri Hospital located in Columbia, Missouri are Medicare-approved facilities for coverage of heart transplants. St. Luke's Hospital in Kansas City, Barnes-Jewish Hospital and St. Louis University are also Medicare-certified liver transplant facilities. Barnes-Jewish Hospital is a Medicare approved lung transplant facility. Potential heart, lung and liver transplant candidates who have Medicare coverage or who will be eligible for Medicare coverage within six months from the date of imminent need for the transplant should be referred to one of the approved Medicare transplant facilities. MO HealthNet only considers authorization of a Medicare-covered transplant in a non-Medicare transplant facility if the Medicare beneficiary is too ill to be moved to the Medicare transplant facility.

END OF SECTION

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SECTION 2-PROVIDER CONDITIONS OF PARTICIPATION

2.1 PROVIDER ELIGIBILITY

To receive MO HealthNet reimbursement, a provider of services *must* have entered into, and maintain, a valid participation agreement with the MO HealthNet Division as approved by the Missouri Medicaid Audit and Compliance Unit (MMAC). Authority to take such action is contained in 13 CSR 70-3.020. Each provider type has specific enrollment criteria, e.g., licensure, certification, Medicare certification, etc., which *must* be met. The enrollment effective date cannot be prior to the date the completed application was received by the MMAC Provider Enrollment office. The effective date cannot be backdated for any reason. Any claims billed by a non-enrolled provider utilizing an enrolled provider's National Provider Identifier (NPI) or legacy number will be subject to recoupment of claim payments and possible sanctions and may be grounds for allegations of fraud and will be appropriately pursued by MMAC. Refer to Section 13, Benefits and Limitations, of the applicable provider manual for specific enrollment criteria.

2.1.A QMB-ONLY PROVIDERS

Providers who want to enroll in MO HealthNet to receive payments for only the Qualified Medicare Beneficiary (QMB) services *must* submit a copy of their state license and documentation of their Medicare ID number. They *must* also complete a short enrollment form. For a discussion of QMB covered services refer to Section 1 of this manual.

2.1.B NON-BILLING MO HEALTHNET PROVIDER

MO HealthNet managed care health plan providers who have a valid agreement with one or more managed care health plans but who are *not* enrolled as a participating MO HealthNet provider may access the Internet or interactive voice response (IVR) system if they enroll with MO HealthNet as a "Non-Billing MO HealthNet Provider." Providers are issued a provider identifier that permits access to the Internet or IVR; however, it is *not* valid for billing MO HealthNet on a fee-for-service basis. Information regarding enrollment as a "Non-Billing MO HealthNet Provider" can be obtained by contacting the Provider Enrollment Unit at: mmac.providerenrollment@dss.mo.gov.

2.1.C PROVIDER ENROLLMENT ADDRESS

Specific information about MO HealthNet participation requirements and enrollment can be obtained from:

Provider Enrollment Unit
Missouri Medicaid Audit and Compliance Unit
P. O. Box 6500
Jefferson City, Missouri 65102
mmac.providerenrollment@dss.mo.gov

2.1.D ELECTRONIC CLAIM/ATTACHMENTS SUBMISSION AND INTERNET AUTHORIZATION

A provider wishing to submit claims or attachments electronically or access the Internet web site, www.emomed.com, *must* be enrolled as an electronic billing provider. Providers wishing to enroll as an electronic billing provider may contact the Wipro Infocrossing Help Desk at (573) 635-3559.

Providers wishing to access the Internet web site, www.emomed.com, *must* complete the on-line Application for MO HealthNet Internet Access Account. Please reference http://manuals.momed.com/Application.html and click on the Apply for Internet Access link. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.

2.1.E PROHIBITION ON PAYMENT TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES

In accordance with the Affordable Care Act of 2010 (the Act), MO HealthNet must comply with the Medicaid payment provision located in Section 6505 of the Act, entitled "Prohibition on Payment to Institutions or Entities Located Outside of the United States." The provision prohibits MO HealthNet from making any payments for items or services provided under the State Plan or under a waiver to any financial institutions, telemedicine providers, pharmacies, or other entities located outside of the U.S., Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. If it is discovered that payments have been made to financial institutions or entities outside of the previously stated approved regions, MO HealthNet must recover these payments. This provision became effective January 1, 2011.

2.2 NOTIFICATION OF CHANGES

A provider *must* notify the Provider Enrollment Unit of any changes affecting the provider's enrollment records within ninety (90) days of the change, in writing, using the appropriate enrollment forms specified by the Provider Enrollment Unit, with the exception of a change in ownership or control of any provider. Change in ownership or control of any provider *must* be reported within thirty (30) days. The Provider Enrollment Unit is responsible for determining whether a current MO HealthNet provider record should be updated or a new MO HealthNet

provider record should be created. A new MO HealthNet provider record is not created for any changes including, but not limited to, a change in ownership, a change of operator, tax identification change, merger, bankruptcy, name change, address change, payment address change, Medicare number change, National Provider Identifier (NPI) change, or facilities/offices that have been closed and reopened at the same or different locations.

2.3 RETENTION OF RECORDS

MO HealthNet providers *must* retain for 5 years (7 years for the Nursing Home, CSTAR and Community Psychiatric Rehabilitation Programs), from the date of service, fiscal and medical records that coincide with and fully document services billed to the MO HealthNet Agency, and *must* furnish or make the records available for inspection or audit by the Department of Social Services, Missouri Medicaid Audit and Compliance Unit, or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to MO HealthNet may result in recovery of the payments for those services *not* adequately documented and may result in sanctions to the provider's participation in the MO HealthNet Program. This policy continues to apply in the event of the provider's discontinuance as an actively participating MO HealthNet provider through change of ownership or any other circumstance.

2.3.A ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. 13 CSR 70-3.030, Section(2)(A) defines "adequate documentation" and "adequate medical records" as follows:

> Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.
>
> Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation *must* be made available at the same site at which the service was rendered.

2.4 NONDISCRIMINATION POLICY STATEMENT

Providers *must* comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable Federal and State Laws that prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs.

Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability, and religious beliefs.

2.5 STATE'S RIGHT TO TERMINATE RELATIONSHIP WITH A PROVIDER

Providers of services and supplies to MO HealthNet participants *must* comply with all laws, policies, and regulations of Missouri and the MO HealthNet Division, as well as policies, regulations, and laws of the federal government. A provider *must* also comply with the standards and ethics of his or her business or profession to qualify as a participant in the program. The Missouri Medicaid Audit and Compliance Unit may terminate or suspend providers or otherwise apply sanctions of administrative actions against providers who are in violation of MO HealthNet Program requirements. Authority to take such action is contained in 13 CSR 70-3.030.

2.6 FRAUD AND ABUSE

The Department of Social Services, Missouri Medicaid Audit and Compliance Unit is charged by federal and state law with the responsibility of identifying, investigating, and referring to law enforcement officials cases of suspected fraud or abuse of the Title XIX Medicaid Program by either providers or participants. Section 1909 of the Social Security Act contains federal penalty provisions for fraudulent acts and false reporting on the part of providers and participants enrolled in MO HealthNet.

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable Federal and State laws, regulations and policies.

Abuse is defined as provider, supplier, and entity practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are *not* medically necessary or that fail to meet professionally recognized standards for health care. It also includes participant practices that result in unnecessary costs to the Medicaid program.

Frequently cited fraudulent or abusive practices include, but are *not* limited to, overcharging for services provided, charging for services *not* rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services.

The penalties for such acts range from misdemeanors to felonies with fines *not* to exceed $25,000 and imprisonment up to 5 years, or both.

Procedures and mechanisms employed in the claims and payment surveillance and audit program include, but are *not* limited to, the following:

- Review of participant profiles of use of services and payment made for such.
- Review of provider claims and payment history for patterns indicating need for closer scrutiny.
- Computer-generated listing of duplication of payments.
- Computer-generated listing of conflicting dates of services.
- Computer-generated overutilization listing.
- Internal checks on such items as claims pricing, procedures, quantity, duration, deductibles, coinsurance, provider eligibility, participant eligibility, etc.
- Medical staff review and application of established medical services parameters.
- Field auditing activities conducted by the Missouri Medicaid Audit and Compliance Unit or its representatives, which include provider and participant contacts.

In cases referred to law enforcement officials for prosecution, the Missouri Medicaid Audit and Compliance Unit has the obligation, where applicable, to seek restitution and recovery of monies wrongfully paid even though prosecution may be declined by the enforcement officials.

2.6.A CLAIM INTEGRITY FOR MO HEALTHNET PROVIDERS

It is the responsibility of each provider to ensure the accuracy of all data transmitted on claims submitted to MO HealthNet, regardless of the media utilized. As provided in 13 CSR 70.3.030, sanctions may be imposed by MO HealthNet against a provider for failure to take reasonable measures to review claims for accuracy. Billing errors, including but not limited to, incorrect ingredient indicators, quantities, days supply, prescriber identification, dates of service, and usual and customary charges, caused or committed by the provider or their employees are subject to adjustment or recoupment. This includes, but is not limited to, failure to review remittance advices provided for claims resulting in payments that do not correspond to the actual services rendered. Ongoing, overt or intentionally misleading claims may be grounds for allegations of fraud and will be appropriately pursued by the agency.

2.7 OVERPAYMENTS

The Missouri Medicaid Audit and Compliance Unit routinely conduct postpayment reviews of MO HealthNet claims. If during a review an overpayment is identified, the Missouri Medicaid Audit and Compliance Unit is charged with recovering the overpayment pursuant to 13 CSR 70-3.030. The Missouri Medicaid Audit and Compliance Unit maintains the position that all providers are held responsible for overpayments identified to their participation agreement regardless of any extrinsic relationship they may have with a corporation or other employing entity. The provider is responsible

for the repayment of the identified overpayments. Missouri State Statute, Section 208.156, RSMo (1986) may provide for appeal of any overpayment notification for amounts of $500 or more. An appeal *must* be filed with the Administrative Hearing Commission within 30 days from the date of mailing or delivery of the decision, whichever is earlier; except that claims of less than $500 may be accumulated until such claims total that sum and, at which time, the provider has 90 days to file the petition. If any such petition is sent by registered mail or certified mail, the petition will be deemed filed on the date it is mailed. If any such petition is sent by any method other than registered mail or certified mail, it will be deemed filed on the date it is received by the Commission.

Compliance with this decision does *not* absolve the provider, or any other person or entity, from any criminal penalty or civil liability that may arise from any action that may be brought by any federal agency, other state agency, or prosecutor. The Missouri Department of Social Services, Missouri Medicaid Audit and Compliance Unit, has no authority to bind or restrict in any way the actions of other state agencies or offices, federal agencies or offices, or prosecutors.

2.8 POSTPAYMENT REVIEW

Services reimbursed through the MO HealthNet Program are subject to postpayment reviews to monitor compliance with established policies and procedures pursuant to Title 42 CFR 456.1 through 456.23. Non-compliance may result in monetary recoupments according to 13 CSR 70-3.030 (5) and the provider may be subjected to prepayment review on all MO HealthNet claims.

2.9 PREPAYMENT REVIEW

MMAC may conduct prepayment reviews for all providers in a program, or for certain services or selected providers. When a provider has been notified that services are subject to prepayment review, the provider *must* follow any specific instructions provided by MMAC in addition to the policy outlined in the provider manual. In the event of prepayment review, the provider *must* submit all claims on paper. Claims subject to prepayment review are sent to the fiscal agent who forwards the claims and attachments to the MMAC consultants.

MMAC consultants conduct the prepayment review following the MO HealthNet Division's guidelines and either recommend approval or denial of payment. The claim and the recommendation for approval or denial is forwarded to the MO HealthNet fiscal agent for final processing. Please note, although MMAC consultants recommend payment for a claim, this does *not* guarantee the claim is paid. The claim *must* pass all required MO HealthNet claim processing edits before actual payment is determined. The final payment disposition on the claim is reported to the provider on a MO HealthNet Remittance Advice.

2.10 DIRECT DEPOSIT AND REMITTANCE ADVICE

MO HealthNet providers *must* complete a Direct Deposit for Individual Provider form to receive reimbursement for services through direct deposit into a checking or savings account. The application should be downloaded, printed, completed and mailed along with a voided check or letter from the provider's financial institution to:

Missouri Medicaid Audit and Compliance (MMAC)

Provider Enrollment Unit

P.O. Box 6500

Jefferson City, MO 65102

This form *must* be used for initial enrollment, re-enrollment, revalidation, or any update or change needed. All providers are required to complete the Application for Provider Direct Deposit form regardless if the reimbursement for their services will be going to another provider.

In addition to completion of the Application for Provider Direct Deposit form, all clinics/groups *must* complete the Direct Deposit for Clinics & Groups form.

Direct deposit begins following a submission of a properly completed application form to the Missouri Medicaid Audit and Compliance Unit, the successful processing of a test transaction through the banking system and the authorization to make payment using direct deposit. The state conducts direct deposit through the automated clearing house system, utilizing an originating depository financial institution. The rules of the National Clearing House Association and its member local Automated Clearing House Association shall apply, as limited or modified by law.

The Missouri Medicaid Audit and Compliance Unit will terminate or suspend the direct deposit for administrative or legal actions, including but *not* limited to: ownership change, duly executed liens or levies, legal judgments, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider, and closure or abandonment of an account.

All payments are direct deposited.

For questions regarding direct deposit or provider enrollment issues, please send an email to mmac.providerenrollment@dss.mo.gov

The MO HealthNet Remittance Advice is available on line. The provider *must* apply online via the Application for MO HealthNet Internet Access Account link.

Once a user ID and password is obtained, the www.emomed.com website can be accessed to retrieve current and aged remittance advices.

Please be aware that any updates or changes made to the emomed file will *not* update the provider master file. Therefore updates or changes should be requested in writing. Requests can be emailed to

the Missouri Medicaid Audit and Compliance Unit, Provider Enrollment Section (www.mmac.providerenrollment@dss.mo.gov).

END OF SECTION

TOP OF SECTION

SECTION 3 - STAKEHOLDER SERVICES

3.1 PROVIDER SERVICES

The MHD has various units to assist providers with questions regarding proper claims filing, claims resolution and disposition, payment problems, participant eligibility verification, prior authorization status, coverage inquiries, and proper billing methods and procedures. Additionally, the Missouri Medicaid Audit and Compliance Unit (MMAC) assists providers with enrollment as an MHD provider, enrollment questions and verifications. Assistance can be obtained by contacting the appropriate unit.

3.1.A MHD TECHNICAL HELP DESK

The MHD Technical Help Desk provides assistance in establishing the required electronic claims and Remittance Advice (RA) formats, network communication, Health Insurance Portability and Accountability (HIPAA) trading partner agreements, and Internet billing service.

This help desk is for use by Fee-For-Service providers, electronic billers, and Managed Care health plan staff. The dedicated telephone number is (573) 635-3559. The responsibilities of the help desk include:

- Front-line assistance to providers and billing staff in establishing required electronic claim formats for claim submission, as well as assistance in the use and maintenance of billing software developed by the MHD.
- Front-line assistance accessibility to electronic claim submission for all providers via the Internet.
- Front-line assistance to Managed Care health plans in establishing required electronic formats, network communications, and ongoing operations.
- Front-line assistance to providers in submitting claim attachments via the Internet.

3.2 Missouri Medicaid Audit & Compliance (MMAC)

MMAC is responsible for administering and managing Medicaid (Title XIX) audit and compliance initiatives and managing and administering provider enrollment contracts under the Medicaid program. MMAC is charged with detecting, investigating and preventing fraud, waste, and abuse. MMAC can be contacted at (573) 751-3399, or access the webpage at http://mmac.mo.gov/.

3.2.A PROVIDER ENROLLMENT UNIT

The MMAC Provider Enrollment Unit processes provider enrollment packets, enrollment applications, and change requests. Information regarding provider participation requirements and enrollment application packets can be obtained by emailing the unit at mmac.providerenrollment@dss.mo.gov.

3.3 PROVIDER COMMUNICATIONS UNIT

The Provider Communications Unit responds to specific provider inquiries concerning MHD eligibility and coverage, claim filing instructions, concerns and questions regarding proper claim filing, claims resolution and disposition, and billing errors. The dedicated telephone number is (573) 751-2896.

Current, old or lost RAs can be obtained from the MHD electronic billing website at www.emomed.com.

- In the section "File Management," the provider can request and print a current RA by selecting "Printable Remittance Advice."
- To retrieve an older RA, select "Request Aged RAs," fill out the required information and submit. The next day, the RA will be under "Printable Aged RAs."
- The requested RA will remain in the system for 5 days.

Providers can verify participant eligibility, check amount information, claim information, provider enrollment status and participant annual review date by calling the Provider Communications Unit, by emailing from the eMOMED Contact tab or by utilizing the Interactive Voice Response (IVR) system.

3.3.A INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

The Interactive Voice Response (IVR) system at (573) 751-2896 allows an active MO HealthNet provider five Main inquiry options:

1. For MO HealthNet Participant Eligibility, Press 1.
2. For Check Amount Information, Press 2.
3. For Claim Information, Press 3.
4. For Provider Enrollment Status, Press 4.
5. For Participant Annual Review Date, Press 5.

The IVR system requires a touch-tone phone and is limited to use by active MO HealthNet providers or inactive providers inquiring on dates of service that occurred during their period of enrollment as an active MO HealthNet provider. The 10-digit

National Provider Identification (NPI) number *must* be entered each time any of the IVR options are accessed.

The provider should listen to all eligibility information, particularly the sub-options.

Main Option 1. Participant Eligibility

The caller is prompted to enter the following information:

- Provider's 10 digit NPI number.
- 8-digit MO HealthNet participant's ID (MO HealthNet Identification Number), or 9-digit Social Security Number (SSN) or case-head ID.
- If the inquiry is by the SSN, once the 9-digit SSN is entered, the IVR prompts for the Date of Birth.
- 6-digit Date of birth (mm/dd/yy).
- Dependent date of birth (if inquiry by case-head ID).
- Once the participant's ID is entered, the IVR prompts for dates of service.
- First date of service (mm/dd/yy): Enter in the 6-digit first date of service.
- Last date of service (mm/dd/yy): Enter the 6-digit last date of service
- Upon entry of dates of service, the IVR retrieves coverage information.

For eligibility inquiries, the caller can inquire by individual date of service or a span of dates. Inquiry for a span of dates may ***not*** exceed 31 days. The caller may inquire on future service dates for the current month only. The caller may ***not*** inquire on dates that exceed one year, prior to the current date. The caller is limited to ten inquiries per call.

The caller is given standard MO HealthNet eligibility coverage information, including the Medicaid Eligibility (ME) code, date of birth, date of death (if applicable), county of eligibility, nursing home name and level of care (if applicable), and informational messages about the participant's eligibility or benefits.

The IVR also tells the caller whether the participant has any service restrictions based on the participant's eligibility under Qualified Medicare Beneficiary (QMB) or the Presumptive Eligibility (TEMP) Program. Please reference all the applicable sections of the provider's program manual for QMB and TEMP provisions.

Hospice beneficiaries are identified along with the name and telephone number of the providers of service. Reference the Provider Manuals Section 1 for detailed information on participant eligibility.

Once standard MO HealthNet eligibility information is given, the IVR gives the caller the option to listen to additional eligibility information through a Sub-Option menu.

The Sub-Options menu options include:

- For Health plan and Lock-in Information, Press 1.
- For eye glass and eye exam information, Press 2.

- For Third Party Liability Information, Press 3.
- For Medicare and QMB Information, Press 4.
- For MO HealthNet ID, Name, spelling of name and eligibility information, Press 5.
- For Confirmation Number, Press 6.
- For Another MO HealthNet Participant, Press 7.
- To Return to the Main Menu, Press 8.
- To End this Call, Press 9.
- To speak with a MO HealthNet specialist, Press 0.

The MHD eligibility information is confidential and must be used only for the purpose of providing services and for filing MHD claims.

Sub-Option 1. Health Plan and Lock-in Information

The Health plan and Lock-in Option sub-option 1, if applicable, provides the health plan lock-in information, Primary Care Provider (PCP) lock-in, and other applicable provider lock-in information.

If no lock-in exists for participant, the IVR will state that the participant is not locked in on the date of service requested.

If lock-in exists, then IVR will read up to three records to the caller.

- If health plan lock-in exists, the IVR states the health plan name for services on the applicable dates.
    - "This participant is locked into Health Plan (Health Plan Name) for services on (from date) through (to date). The Health plan Hotline is Are Code (XXX-XXX-XXXX on file)."

- If PCP lock-in exists, the IVR states the provider's name and phone number for services on the applicable dates.
    - "This participant is locked into Provider (Provider Name) for services on (from date) through (to date). The participant's primary care provider is (PCP Name). The lock-in provider's phone number is Area Code (XXX-XXX-XXXX on file)."

This information is also available on www.emomed.com.

Sub-Option 2. Eye Glass and Eye Exam Information

The participant's eyeglass information and last eye exam information can be obtained through the sub-option 2.

- If no eyeglass information exists, the IVR reads that the participant has not received an eye exam and has not received eye glass frames or lenses to date under the MO HealthNet program.

- If frames, lens, and/or exam information exist, then the IVR will read different types of responses based on the data. A couple of examples include:
    - If frames, lens, and exam information exists and all occur on the same date.
    - Date of last eye exam and last issue of eyeglass frames and lenses is (date on file).
    - If frames, lens exist for different dates and no exam date.
    - Eye glass frames were last issued on (Frames Date).
    - Eye glass lenses were last issued on (Lens Date).
    - This participate has not had an eye examination to date under the MO HealthNet program.

This information is also available on the eMOMED website. The IVR goes back to the sub-options.

Sub-Option 3. Third Party Liability (TPL) Information

The participant's TPL information on file will be provided through sub-option 3.

- If no TPL exists for the participant or TPL Name is blank, the IVR reads that information.
- If Medicare Part C exists, the IVR reads that information.
- If TPL Part C information is not available, the IVR reads to contact the participant for the information.
- If Medicare Part C does not exist, the IVR reads that this participant does not have Third party coverage on the dates of service requested.
- If TPL exists, then IVR will read up to **five** records to the caller.
    - Third party insurance is provided by (TPL NAME).
    - If Court Ordered, the IVR will read that this coverage is court ordered.
    - If Policy Number = 'unknown, the IVR will read that the Policy number is unknown.
    - If Policy Number is known, the IVR will read the policy number is (Policy Number).
    - If Group Number = 'unknown, the IVR will read that the group number is unknown.
    - If the Group Number is known, the IVR will read that the group number is (Group Number).

This information is also available on the eMOMED website. The IVR goes back to the sub-options.

Sub-Option 4 Medicare and QMB Information

If no Part A, B, or QMB information exists on file for the participant, then nothing is read.

If Part A, B, and/or QMB information exists then the IVR will read different types of responses based on the data on file. A couple of examples include:

- If Part A, B, QMB exists and all have same dates, the IVR will read that this participant has Medicare Part A, Part B, and QMB coverage on (from date) through (to date).
- If Part A, B exists for same dates and QMB has different dates, the IVR will read that this participant has Medicare Part A and Part B coverage on (from date) through (to date). This participant has QMB coverage on (QMB from date) through (QMB to date).
- If Part C exists, the IVR will read that this participant has Medicare Part C coverage on (from date) through (to date).

This information is also available on the eMOMED website. The IVR goes back to the sub-options.

Main Option 2. Provider IVR Check Inquiry

Once the provider's 10 digit NPI number is entered, the IVR retrieves the information. The IVR will read if the provider is eligible to submit electronic claims, or if the provider is not eligible to submit electronic claims.

- The IVR will read the most recent provider check information available from the Remittance Advice number (RA Number) dated (RA Date). The check amount is (RA Amount).
- If there has not been checks issued, the IVR will read that the NPI Number (XXXXXXXXXX) has not been issued any checks to date.

This information is also available on the eMOMED website.

The IVR then reads additional navigation options.

- For another Check Inquiry, Press 1. If the caller presses 1, the IVR goes back to Provider Check Inquiry.
- To repeat the information that you just heard, Press 2. If the caller presses 2, the IVR goes back to the Main Menu
- To Speak with a MO HealthNet specialist, Press 0.
- Else, Press 3.

Main Option 3. Provider IVR Claim Information

The provider can access claim status information, including processing status, denial, and approved status.

- Once the 10 digit provider NPI number is entered, then IVR prompts for the 8 digit MO HealthNet ID.
- Once 8 digit number is entered, the IVR prompts for the 6 digit first date of service in (mm/dd/yy) format.
- Once 6 digit number is entered, the IVR prompts for the type of claim.
    - If Drug claim is selected, then IVR prompts for prescription number entry.

Once inputs are received, the IVR retrieves the following results:

- If claim is in process:
    - The IVR reads that the claim accessed with this date of service is being processed.
- If claim is denied:
    - The IVR will read up to five Explanation of Benefits (EOB) applicable codes. The claim accessed with this date of service has been denied with EOB (EOB Code 1-5).
    - After EOB codes are read, the IVR prompts to hear EOB descriptions.
    - Press 1 for EOB Description. If the caller presses 1, the IVR will read the EOB descriptions for the EOB codes (up to **five**).
- IVR then reads RA information. If the claim is denied, the IVR reads that the claim accessed with this date of service is denied on the (RA Number) Remittance Advice dated (RA Date).
- If claim is approved for payment:
- The IVR reads that the claim accessed with this date of service has been approved for payment.
- If claim paid and the claim is being recouped or adjusted, the IVR reads for more information, speak with a MO HealthNet Specialist.
- If claim paid, the IVR will read that the claim accessed with this date of service was paid on the (RA Number) Remittance Advice dated (RA Date) in the amount of (RA Amount).

This information is also available on the eMOMED website. The IVR then reads the following navigation options:

- For another Claim inquiry, Press 1. If the caller presses 1, IVR goes back to Provider Claim Inquiry.
- To repeat the information that you just heard, Press 2. If the caller presses 2, IVR repeats Response information.
- To speak with a MO HealthNet specialist, Press 0.
- If the caller presses 3, IVR goes back to the Main Menu.

Main Option 4. Provider Enrollment Status

The provider's enrollment status can be obtained through this option. The following will be repeated up to five times depending on the number of providers for the inquiry. The caller is prompted to enter the provider's NPI number.

- Please enter the 10 digit NPI number. Once 10 digit NPI number is entered, the IVR prompts for NPI number in which being inquired.
- Please enter the 10 digit NPI number in which being inquired. Once 10 digit number is entered, the IVR prompts for date of service.
- Please enter the 6 digit Date of Service in (MM/DD/YY) format. Once inputs are received, the IVR retrieves results.

The following will be repeated up to **five** times depending on the number of providers for the inquired NPI.

- The Provider Enrollment Status for NPI (NPI Number) with a provider type of (Provider Type Description) is (Active/Not Active) for the date of service (DOS). The confirmation number is (Confirmation Number).

This information is also available on the eMOMED website.

The IVR then reads the following navigation options:

- For another Provider Enrollment Status Inquiry, Press 1. If the caller presses 1, the IVR goes back to the Provider Enrollment Option.
- To repeat the information that you just heard, Press 2. If the caller presses 2, the IVR repeats the Provider Enrollment response.
- To Speak with a MO HealthNet specialist, Press 0
- If the caller presses 3, the IVR goes back to the Main Menu.

Main Option 5. Participant Annual Review Date

The participant's annual review date can be obtained through this option. The only information retrieved is the annual review date. For specific information, call the Family Support Division at 1-855-373-4636.

The caller is prompted to enter the following information.

- Please enter the 10 digit NPI number. Once a valid 10 digit number is entered, the IVR prompts for the participant MO HealthNet ID.
- Please enter the 8 digit MO HealthNet ID. Once a valid 8 digit number is entered, the IVR retrieves Data.
- If valid annual review date found, the IVR reads the following.
    - MO HealthNet ID (MO HealthNet ID) is registered to (First, Last Name). Annual Review Date (date on file). For information specific to the MO

HealthNet Participant Annual Review Date, please call the Family Support Division Information Center at 1-855-373-4636.

•If Annual Review Date is not on file, the IVR reads the following:

"MO HealthNet ID (MO HealthNet ID) Annual Review Date is not on file. For information specific to the MO HealthNet Participant Annual Review Date, please call the Family Support Division Information Center at 1-855-373-4636."

After valid or error response IVR then reads menu options.

- For Another MO HealthNet Participant, Press 1. If the caller presses 1, IVR goes back to Enter MO HealthNet ID prompt.
- To repeat the information that you just heard, Press two. If the caller presses 2, IVR repeats the Annual Review Date response.
- If the caller presses 3, the IVR goes back to the Main Menu.
- If the provider selects to speak to a specialist, the IVR will route to a specialist.

Transfer Routine

The provider must go through one of the available options on the IVR, prior to requesting an agent. If the inquiry cannot be answered through the IVR, please go through an option and wait to be prompted to be routed to a specialist. The IVR will respond to please hold while we transfer you to a MO HealthNet Specialist. Please have your NPI number ready.

Number of Inquiries

There are 10 inquiries allowed per caller. If 10 inquiries are accessed, the IVR will read that you have used your allotted 10 participant inquiries per call, thank you for calling, and hangs up.

3.3.A(1) Using the Telephone Key Pad

Both alphabetic and numeric entries may be required on the telephone key pad. In some cases, the IVR instructs the caller which numeric values to key to match alphabetic entries.

Please listen and follow the directions given by the IVR, as it prompts the caller for the various information required by each option. Once familiar with the IVR, the caller does *not* have to wait for the entire voice prompt. The caller can enter responses before the prompts are given.

3.3.B MO HEALTHNET SPECIALIST

Specialists are on duty between the hours of 8:00 AM and 5:00 PM, Monday through Friday (except holidays) when information is not clearly provided or available through the IVR system. The IVR number is (573) 751-2896. Providers are urged to do the following prior to calling:

• Review the provider manual and bulletins before calling the IVR.

• Have all material related to the problem (such as RA, claim forms, and participant information) available for discussion.

• Have the provider's NPI number available.

• Limit the call to three questions. The specialist will assist the provider until the problem is resolved or until it becomes apparent that a written inquiry is necessary to resolve the problem.

• Note the name of the specialist who answered the call. This saves a duplication of effort if the provider needs to clarify a previous discussion or to ask the status of a previous inquiry.

Please note that there are no limits on how many inquiries you can access through the MHD web-based www.emomed.com system. Limitations associated with the number of inquiries are only applicable to the IVR, speaking with a specialist, and email communications.

3.3.C INTERNET

Providers may submit claims on the internet via the MHD web based electronic claims filing system. The website address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please access the application http://manuals.momed.com/Application.html. and select the Apply for Internet Access link. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.

The internet inquiry options, located at www.emomed.com, include the same inquiry options available through the IVR system (without limited number of inquiry restrictions). Providers are encouraged to use www.emomed.com as the first option, prior to accessing the IVR. The provider will be able to read and review the data and results, instead of having to call to hear the results. All the same functions and additional functions compared to the IVR are available and include: eligibility verification by Participant ID, case head ID and child's date of birth, or Social Security Number and date of birth, claim status, and check inquiry, provider enrollment status, and participant annual review date. Eligibility verification can be performed on an individual basis or as a batch submission. Individual eligibility verifications occur in real-time similar to the IVR, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

Providers also have the capability to receive and download their RAs from www.emomed.com. Access to this information is restricted to users with authorization. In addition to the\RA, the claim reason codes, remark codes and current fiscal year claims processing schedule is available on the Internet for viewing or downloading.

Other options available on this website (www.emomed.com.) include: claim submission, claim attachment submission, inquiries on claim status, attachment status, and check amounts, and credit adjustment(s). Reference the Provider Manuals Section 1 for detailed information on participant eligibility.

3.3.D WRITTEN INQUIRIES

Letters directed to the MHD are answered by MO HealthNet specialists in the Provider Communications Unit. Written or telephone responses are provided to all inquiries. A provider who encounters a complex billing problem, numerous problems requiring detailed and lengthy explanation of such matters as policy, procedures, and coverage, or wishes to submit a complaint should submit the inquiry or complaint in writing to:

Provider Communications Unit
MO HealthNet Division
P.O. Box 5500
Jefferson City, MO 65102-5500

A written inquiry should state the problem as clearly as possible and should include the following:

- Provider's name
- NPI number
- Address
- Telephone number
- MO HealthNet participant's full name
- MO HealthNet participant’s identification number
- MO HealthNet participant’s birthdate
- A copy of all pertinent information such as the following:
    - Remittance Advice forms
    - Invoices
    - Applicable Participant Information
    - Form letters
    - Timely filing documentation *must* be included with the written inquiry, if applicable.

3.4 PROVIDER EDUCATION UNIT

The Provider Education Unit serves as a communication and assistance liaison between the MHD and the provider community. Provider Education Representatives can provide face-to-face assistance and personalized attention necessary to maintain clear, effective, and efficient provider participation in the MHD. Providers contribute to this process by identifying problems and difficulties encountered with MO HealthNet.

Representatives are available to educate providers and other groups on proper billing methods and procedures for MHD claims. The representatives provide assistance, training, and information to enhance provider participation in MO HealthNet. These representatives schedule seminars, workshops, and Webinar trainings for individuals and associations to provide instructions on procedures, policy changes, and benefit changes, which affect the provider community.

The Provider Education Unit can be contacted for training information and scheduling via telephone at (573) 751-6683 or email at mhd.provtrain@dss.mo.gov. Providers can visit the Provider Participation page at http://dss.mo.gov/mhd/providers to schedule training.

3.5 PARTICIPANT SERVICES

The Participant Services Unit assists participants regarding access to providers, eligibility, covered and non-covered services, unpaid medical bills, premium collections questions, and payment information. The Participant Services Number is (800) 392-2161 or (573) 751-6527.

Providers may direct participants to the MO HealthNet Participant Services Unit when they need assistance in any of the above-mentioned situations. For example, when a participant moves to a new area of the state and needs the names of all physicians who are active MO HealthNet providers in the new area.

When participants have problems or questions concerning their MO HealthNet coverage, they should be directed to call or write to the Participant Services Unit at:

Participant Services Unit
MO HealthNet Division
P.O. Box 3535
Jefferson City, MO 65102-3535

All calls or correspondence from providers are referred to the Provider Communications Unit. Please ***do not*** give participants the Provider Communications' telephone number.

3.6 PENDING CLAIMS

If payment or status information, for a submitted MO HealthNet claim, is ***not*** received within 60 days, providers should call the Provider Communications Unit at 573-751-2896, to discuss submission of a new claim or status of the previously submitted claim. However, providers should not resubmit a new claim for a claim that remains in pending status. Resubmitting a claim in pending status will delay processing of the claim. Reference the Provider Manuals Section 17 for further discussion of the RA and Suspended Claims.

3.7 FORMS

All MO HealthNet forms necessary for claims processing are available for download on the MHD website at www.dss.mo.gov/mhd/providers/index.htm. Choose the "MO HealthNet forms" link in the right column.

3.8 CLAIM FILING METHODS

Some providers may submit paper claims. All claim types may be submitted electronically through the MHD billing site at www.emomed.com. Most claims that require attachments may also be submitted at this site.

Pharmacy claims may also be submitted electronically through a point of service (POS) system. Medical (CMS-1500), Inpatient and Outpatient (UB-04), Dental (ADA 2002, 2004), Nursing Home and Pharmacy (NCPDP) may also be submitted via the Internet. These methods are described in the Provider Manuals Section 15. NOTE: Effective November 1, 2020 MHD will accept the 2019 ADA form for dental claims.

3.9 CLAIM ATTACHMENT SUBMISSION VIA THE INTERNET

The claim attachments available for submission via the Internet include:

- (Sterilization) Consent Form.
- Acknowledgment of Receipt of Hysterectomy Information.
- Medical Referral Form of Restricted Participant (PI-118).
- Certificate of Medical Necessity (for Durable Medical Equipment providers only).

These attachments may *not* be submitted via the Internet when additional documentation is required. The web site address for these submissions is www.emomed.com.

3.10 Pharmacy & Clinical Services Unit

This unit assists with program development and clinical policy decision making for MHD. These responsibilities include policy development, benefit design, and coverage decisions using best practices and evidence-based medicine. The Pharmacy and Clinical Services Unit can be contacted at (573) 751-6963, or by emailingMHD.ClinicalServices@dss.mo.gov, or visit the MHD webpage at http://dss.mo.gov/mhd/cs/.

Providers with problems or questions regarding policies and programs, which cannot be answered by any other means, should email Ask.MHD@dss.mo.gov.

3.11 Pharmacy and Medical Pre-certification Help Desk

The MHD requires pre-certification for certain radiological procedures. Certain drugs require a Prior Authorization (PA) or Edit Override (EO), prior to dispensing. To obtain these pre-certifications, PA's or EO's, providers can call 800-392-8030, or use the CyberAccess website, a web tool that automates this process for MO HealthNet providers.

To become a CyberAccess user, contact the help desk at 888-581-9797 or 573-632-9797, or email cyberaccesshelpdesk@xerox.com. For non-emergency service or equipment exception requests only, please use Fax #: (573) 522-3061; Drug PA Fax #: (573) 636-6470.

3.12 Third Party Liability (TPL)

Providers should contact the TPL Unit to report any MO HealthNet participant who has sustained injuries due to an accident or when they have problems obtaining a response from an insurance carrier. Any unusual situations concerning third party insurance coverage for a MO HealthNet participant should also be reported to the TPL Unit. The TPL Unit's number is 573-751-2005.

SECTION 4 - TIMELY FILING

4.1 TIME LIMIT FOR ORIGINAL CLAIM FILING

4.1.A MO HEALTHNET CLAIMS

Claims from participating providers who request MO HealthNet reimbursement *must* be filed by the provider and *must* be received by the state agency within 12 months from the date of service. The counting of the 12-month time limit begins with the date of service and ends with the date of receipt. Refer to Section 4.5, Definitions, for a detailed explanation of terms.

4.1.B MEDICARE/MO HEALTHNET CLAIMS

Claims that initially have been filed with Medicare within the Medicare timely filing requirement and that require separate filing of a claim with the MHD meet the timely filing requirement by being submitted by the provider and received by the state agency within 12 months from the date of service or 6 months from the date on Medicare's provider notice of the allowed claim, whichever is later. Claims denied by Medicare *must* be filed by the provider and received by the state agency within 12 months from the date of service. The counting of the 12-month time limit begins with the date of service and ends with the date of receipt. The counting of the 6-month period begins with the date of adjudication of Medicare payment and ends with the date of receipt.

Refer to Section 16 for billing instructions of Medicare/MO HealthNet (crossover) claims.

4.1.C MO HEALTHNET CLAIMS WITH THIRD PARTY LIABILITY

Claims for participants who have other insurance *must* first be submitted to the insurance company in most instances. Refer to Section 5 for exceptions to this rule. However, the claim *must* still meet the MHD timely filing guidelines outlined above. (Claim disposition by the insurance company after 1 year from the date of service does *not* serve to extend the filing requirement.) If the provider has *not* had a response from the insurance company prior to the 12-month filing limit, they should contact the Third Party Liability (TPL) Unit at (573) 751-2005 for billing instructions. It is recommended that providers wait *no* longer than 6 months after the date of service before contacting the TPL Unit. If the MHD waives the requirement that the third-party resource's adjudication *must* be attached to the claim, documentation indicating the third-party resource's adjudication of the claim *must* be kept in the provider's records and made available to the division at its request. The claim *must* meet the MHD timely filing requirement by being filed by the provider and received by the state agency within 12 months from the date of service.

The 12 month initial filing rule may be extended if a third-party payer, after making a payment to a provider, being satisfied that the payment is correct, later reverses the payment determination, sometime after the 12 months from the date of service has elapsed, and requests the provider return the payment. Because a third-party resource was clearly available to cover the full amount of liability, and this was known to the provider, the provider may *not* have initially filed a claim with the MHD. Under this set of circumstances, the provider may file a claim with the MHD later than 12 months from the date of service. The provider *must* submit this type of claim to the Third Party Liability Unit at P.O. Box 6500, Jefferson City, MO 65102-6500 for special handling. The MHD may accept and pay this specific type of claim without regard to the 12 month timely filing rule; however, all claims *must* be filed for MO HealthNet reimbursement within 24 months from the date of service in order to be paid.

4.2 TIME LIMIT FOR RESUBMISSION OF A CLAIM

Claims that were originally submitted and received within 12 months from the date of service and were denied or returned to the provider *must* be resubmitted and received within 24 months of the date of service.

4.2.A CLAIMS FILED AND DENIED

Claims that are denied may be resubmitted. A resubmission filed beyond the 12-month filing limit *must* either include an attachment, a Remittance Advice or Return to Provider letter, or the claim *must* have the original ICN entered in the appropriate field for electronic or paper claims (reference Section 15 of the applicable provider manual). Either the attachment or the ICN *must* indicate the claim had originally been filed within 12 months of the date of service. The same Remittance Advice, letter or ICN can be used for each resubmission of that claim.

4.2.B CLAIMS FILED AND RETURNED TO PROVIDER

Some paper claims received by the fiscal agent *cannot* be processed because the wrong claim form is submitted or additional data is required. These claims are *not* processed through the system but are returned to the provider with a Return to Provider letter. When these claims are resubmitted more than 12 months after the date of service (and had been filed timely), a copy of the Return to Provider letter should be attached instead of the required Remittance Advice to document timely filing as explained in the previous paragraph. The date on the letter determines timely filing.

4.3 CLAIMS NOT FILED WITHIN THE TIME LIMIT

In accordance with 13 CSR 70-3.100, claims that are *not* submitted in a timely manner as described in this section are denied. However, at any time in accordance with a court order, the the MHD may make payments to carry out a hearing decision, corrective action or court order to others in the same situation as those directly affected by it. As determined by the state agency, the MHD *may* make payment if a claim was denied due to state agency error or delay. In order for payment to be made, the MHD *must* be informed of any claims denied due to the MHD error or delay within 6 months from the date of the remittance advice on which the error occurred; or within 6 months of the date of completion or determination in the case of a delay; or 12 months from the date of service, whichever is longer.

4.4 TIME LIMIT FOR FILING AN INDIVIDUAL ADJUSTMENT

Adjustments to MO HealthNet payments are only accepted if filed within 24 months from the date of service. If the processing of an adjustment necessitates filing a new claim, the timely limits for resubmitting the new, corrected claim is 24 months from the date of service. Providers can resubmit an adjusted claim via the MHD billing website located at www.emomed.com. When overpayments are discovered, it is the responsibility of the provider to notify the state agency. Providers must submit a Provider Initiated Self Disclosure Report Form (here). The form must be submitted within 24 months of the date of service. Only adjustments or disclosures that are the result of lawsuits or settlements are accepted beyond 24 months.

4.5 DEFINITIONS

Claim: Each individual line item of service on a claim form for which a charge is billed by a provider for all claim form types except inpatient hospital. An inpatient hospital service claim includes all the billed charges contained on one inpatient claim document.

Date of Service: The date that serves as the beginning point for determining the timely filing limit. For such items as dentures, hearing aids, eyeglasses, and items of durable medical equipment such as an artificial larynx, braces, hospital beds, or wheelchairs, the date of service is the date of delivery or placement of the device or item. It applies to the various claim types as follows:

- **Nursing Homes**: The last date of service for the billing period indicated on the participant's detail record. Nursing Homes *must* bill electronically, unless attachments are required.
- **Pharmacy**: The date dispensed.
- **Outpatient Hospital**: The ending date of service for each individual line item on the claim form.

- **Professional Services**: The ending date of service for each individual line item on the claim form.
- **Dental**: The date service was performed for each individual line item on the claim form.
- **Inpatient Hospital**: The through date of service in the area indicating the period of service.

Date of Receipt: The date the claim is received by the fiscal agent. For a claim that is processed, this date appears as the Julian date in the internal control number (ICN). For a claim that is returned to the provider, this date appears on the Return to Provider letter.

Date of Adjudication: The date that appears on the Remittance Advice indicating the determination of the claim.

Internal Control Number (ICN): The 13-digit number printed by the fiscal agent on each document that processes through the claims processing system. The first two digits indicate the type of claim. The year of receipt is indicated by the 3rd and 4th digits, and the Julian date appears as the 5th, 6th, and 7th digits. For example, in the number 4912193510194, "49" is an eMOMED claim, "17" is the year 2017, and "193" is the Julian date for July 11.

Julian Date: The number of a day of the year when the days of the year are numbered consecutively from 001 (January 1) to 365 (December 31) or 366 in a leap year. For example, in 2016, a leap year, June 15 is the 167th day of that year; thus, 167 is the Julian date for June 15, 2016.

Date of Payment/Denials: The date on the Remittance Advice at the top center of each page under the words "Remittance Advice."

Twelve-Month Time Limit Unit: 366 days.

Six-Month Time Limit: 181 days.

Twenty-four-Month Time Limit: 731 days.

END OF SECTION

TOP OF PAGE

SECTION 5-THIRD PARTY LIABILITY

5.1 GENERAL INFORMATION

The purpose of this section of the provider manual is to provide a good understanding of Third Party Liability (TPL) and MO HealthNet. The federal government defines a third party resource (TPR) as:

> "Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State Plan."

The following is a list of common TPRs; however, the list should *not* be considered to be all inclusive.

Assault—Court Ordered Restitution
Automobile—Medical Insurance
Tricare
Health Insurance (Group or Private)
Homeowner's Insurance
Liability & Casualty Insurance
Malpractice Insurance
Medical Support Obligations
Medicare
Owner, Landlord & Tenant Insurance
Probate
Product Liability Insurance
Trust Accounts for Medical Services Covered by MO HealthNet
Veterans' Benefits
Worker's Compensation.

5.1.A MO HEALTHNET IS PAYER OF LAST RESORT

MO HealthNet funds are used after all other potential resources available to pay for the medical service have been exhausted. There are exceptions to this rule discussed later in this section. The intent of requiring MO HealthNet to be payer of last resort is to ensure that tax dollars are *not* expended when another liable party is responsible for all or a portion of the medical service charge. It is to the provider's benefit to bill the liable TPR before billing MO HealthNet because many resources pay in excess of the maximum MO HealthNet allowable.

Federal and state regulations require that insurance benefits or amounts resulting from litigation are to be utilized as the first source of payment for medical expenses incurred by MO HealthNet participants. See 42 CFR 433 subpart D and RSMo 208.215 for further

reference. In essence, MO HealthNet does *not* and should *not* pay a claim for medical expenses until the provider submits documentation that all available third party resources have considered the claim for payment. Exceptions to this rule are discussed later in this section of the provider manual.

All TPR benefits for MO HealthNet covered services *must* be applied against the provider's charges. These benefits *must* be indicated on the claim submitted to MO HealthNet. Subsequently, the amount paid by MO HealthNet is the difference between the MO HealthNet allowable and the TPR benefit amount, capping the payment at the MO HealthNet allowable. For example, a provider submits a charge for $100 to the MO HealthNet Program for which the MO HealthNet allowable is $80. The provider received $75 from the TPR. The amount MO HealthNet pays is the difference between the MO HealthNet allowable ($80) and the TPR payment ($75) or $5.

5.1.B THIRD PARTY LIABILITY FOR MANAGED CARE ENROLLEES

Managed care health plans in the MO HealthNet Managed Care program *must* ensure that the health plan and its subcontractors conform to the TPL requirements specified in the managed care contract. The following outlines the agreement for the managed health care plans.

The managed care health plan is responsible for performing third party liability (TPL) activities for individuals with private health insurance coverage enrolled in their managed care health plan.

By law, MO HealthNet is the payer of last resort. This means that the managed care health plan contracted with the State of Missouri shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The two methods used in the coordination of benefits are cost avoidance and post-payment recovery (i.e., pay and chase). The managed care health plan shall act as an agent of the state agency for the purpose of coordination of benefits.

The managed care health plan shall cost avoid all claims or services that are subject to payment from a third party health insurance carrier. If a third party health insurance carrier (other than Medicare) requires the managed care health plan member to pay any cost-sharing amount (such as copayment, coinsurance or deductible), the managed care health plan is responsible for paying the cost-sharing (even to an out-of-network provider). The managed care health plan's liability for such cost-sharing amounts shall *not* exceed the amount the managed care health plan would have paid under the managed care health plan's payment schedule.

If a claim is cost-avoided, the establishment of liability takes place when the managed care health plan receives confirmation from the provider or the third party health insurance carrier indicating the extent of liability.

If the probable existence of a Third Party Resource (TPR) *cannot* be established or third party benefits are *not* available at the time the claim is filed, the managed care health plan *must* pay the full amount allowed under the managed care health plan's payment schedule.

The managed care health plan must provide labor, delivery, and postpartum care; prenatal care for pregnant women; preventive pediatric services; and services that are provided to a Managed Care member on whose behalf a child support enforcement order is in effect. If a third party liability payer exists for these services, the provider may bill the third party liability payer.

The managed care health plan shall apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum services. The health plan shall make payments without regard to potential TPL for pediatric preventive services, unless they have made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days. The health plan shall make payments to providers if payment has not been made from a third party liability derived from a child support enforcement order within 100 days after the provider has initially submitted a claim to such third party for payment of Medicaid services.

If the third party resource is derived from a non-custodial parent whose medical support obligation is being enforced by the Family Support Division 42 CFR 433.139 (b)(3)requires the state Medicaid agency to pay and chase these claims when the provider has billed the TPR and been unable to obtain payment and 100 days have passed since the date of service. The provider must submit an attestation that all conditions have been met in order to receive payment.

In addition to coordination of benefits, the health plan shall pursue reimbursement in the following circumstances:

- Worker's Compensation
- Tort-feasors
- Motorist Insurance
- Liability/Casualty Insurance

The managed care health plan shall immediately report to the MO HealthNet Division any cases involving a potential TPR resulting from any of the above circumstances. The managed care health plan shall cooperate fully with the MO HealthNet Division in all collection efforts. If the managed care health plan or any of its subcontractors receive reimbursement as a result of a listed TPR, that payment *must* be forwarded to the MO HealthNet Division immediately upon receipt.

IMPORTANT: Contact the MO HealthNet Division, Third Party Liability Unit, at (573) 751-2005 for questions about Third Party Liability.

5.1.C PARTICIPANTS LIABILITY WHEN THERE IS A TPR

The provider may *not* bill the participant for any unpaid balance of the total MO HealthNet covered charge when the other resource represents all or a portion of the MO HealthNet maximum allowable amount. The provider is *not* entitled to any recovery from the participant except for services/items which are *not* covered by the MO HealthNet Program or services/items established by a written agreement between the MO HealthNet participant and provider indicating MO HealthNet is *not* the intended payer for the specific service/item but rather the participant accepts the status and liability of a private pay patient.

Missouri regulation does allow the provider to bill participants for MO HealthNet covered services if, due to the participant's action or inaction, the provider is *not* reimbursed by the MO HealthNet Program. It is the provider's responsibility to document the facts of the case. Otherwise, the MO HealthNet agency rules in favor of the participant.

5.1.D PROVIDERS MAY NOT REFUSE SERVICE DUE TO TPL

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 contained a number of changes affecting the administration of a state's Medicaid TPL Program. A provision of this law implemented by Federal Regulations effective February 15, 1990, is described below:

> Under law and federal regulation, a provider may *not* refuse to furnish services covered under a state's Medicaid plan to an individual eligible for benefits because of a third party's potential liability for the service(s). See 42 CFR 447.20(b).

This provision prohibits providers from discriminating against a MO HealthNet participant based on the possible existence of a third party payer. A participant may *not* be denied services based solely on this criterion. Federal regulation does provide the state with authority to sanction providers who discriminate on this basis.

A common misconception is that incorrect information regarding third party liability affects participant eligibility. Providers have refused services to participants until the third party information available to the state is either deleted or changed. Third party information reflects the participant's records at the time the MO HealthNet eligibility is verified and is used to notify providers there is probability of a third party resource. Current MO HealthNet third party information is used when processing provider claims. Therefore, incorrect third party information does *not* invalidate the participant's eligibility for services. The federal regulation cited in the paragraph above prohibits providers from refusing services because of incorrect third party information in the participant's records.

5.2 HEALTH INSURANCE IDENTIFICATION

Many MO HealthNet participants are dually eligible for health insurance coverage through a variety of sources. The provider should always question the participant or caretaker about other possible insurance coverage. While verifying participant eligibility, the provider is provided information about possible insurance coverage. The insurance information on file at the MO HealthNet Division (MHD) does *not* guarantee that the insurance(s) listed is the only resource(s) available nor does it guarantee that the coverage(s) remains available.

5.2.A TPL INFORMATION

MO HealthNet participants may contact Participant Services, (800) 392-2161, if they have any questions concerning their MO HealthNet coverage. Providers may reference a point of service (POS) terminal, the Internet or they may call the interactive voice response (IVR) system at (573) 635-8908 for TPL information. Refer to Sections 1 and 3 for further information.

In addition to the insurance company name, city, state and zip code, the Internet, IVR or POS terminal also gives a code indicating the type of insurance coverage available (see Section 5.3). For example, if "03" appears in this space, then the participant has hospital, professional and pharmacy coverage. If the participant does *not* have any additional health insurance coverage either known or unknown to the MO HealthNet agency, a provider *not* affected by the specified coverage, such as a dental provider, does *not* need to complete any fields relating to TPL on the claim form for services provided to that participant.

5.2.B SOLICITATION OF TPR INFORMATION

There may be coverage available to the participant that is *not* known to MHD. It is the provider's responsibility and in his/her best interest to solicit TPR information from the participant or caretaker at the time service is provided whether or not MHD is aware of the availability of a TPR. The fact that the TPR information is unknown to MHD at the time service is provided does *not* release the liability of the TPR or the underlying responsibility of the provider to utilize those TPR benefits.

A few of the more common health insurance resources are:

- If the participant is married or employed, coverage may be available through the participant's or spouse's employment.
- If the participant is a foster child, the natural parent may carry health insurance for that child.
- The noncustodial parent may have insurance on the child or may be ordered to provide health insurance as part of his/her child support obligation.

- Tricare or veteran's benefits may provide coverage for families of active duty military personnel, retired military personnel and their families, and for disabled veterans, their families and survivors. A veteran may have additional medical coverage if the veteran elected to be covered under the "Improved Pension Program," effective in 1979.
- If the participant is 65 or over, it is very likely that they are covered by Medicare. To meet Medicare Part B requirements, individuals need only be 65 (plus a residency requirement for aliens or refugees) and the Part B premium be paid. Individuals who have been receiving kidney dialysis for at least 3 months or who have received a kidney transplant may also be eligible for Medicare benefits. (For Medicare related billings, see the Medicare Crossover Section in this manual.)
- If the participant is disabled, coverage may exist under Medicare, Worker's Compensation, or other disability insurance carriers.
- If the participant is an over age disabled dependent (in or out of school), coverage may exist as an over age dependent on most group plans.
- If the participant is in school, coverage may exist through group plans.
- A relative may be paying for health insurance premiums on behalf of the participant.

5.3 INSURANCE COVERAGE CODES

Listed below are the codes that identify the type of insurance coverage the participant has:

AC Accident

AM Ambulance

CA Cancer

CC Nursing Home Custodial Care

DE Dental

DM Durable Medical Equipment

HH Home Health

HI Inpatient Hospital

HO Outpatient Hospital—includes outpatient and other diagnostic services

HP Hospice

IN Hospital Indemnity—refers to those policies where benefits *cannot* be assigned and it is *not* an income replacement policy

MA Medicare Supplement Part A

MB Medicare Supplement Part B

MD Physician—coverage includes services provided and billed by a health care professional

MH Medicare Replacement HMO

PS Psychiatric—physician coverage includes services provided and billed by a health care professional

RX Pharmacy

SC Nursing Home Skilled Care

SU Surgical

VI Vision

5.4 COMMERCIAL HEALTH CARE PLANS

Employers frequently offer commercial health care plans to their employees in an effort to keep insurance costs more reasonable. Most of these policies require the patient to use the plan's designated health care providers. Other providers are considered "out-of-plan" and those services are *not* reimbursed by the commercial health care plan unless a referral was made by the commercial health care plan provider or, in the case of emergencies, the plan authorized the services (usually within 48 hours after the service was provided). Some commercial health care policies pay an out-of-plan provider at a reduced rate.

MO HealthNet only reimburses providers who are *not* affiliated with the commercial health care plan if the commercial health care plan has paid primary or there is a legitimate denial from the commercial health plan, and MO HealthNet is paying secondary. See section 5.6.B for additional information on legitimate denials.

Frequently, commercial health care plans require a copayment from the patient in addition to the amounts paid by the insurance plan. MO HealthNet does *not* reimburse copayments. This copayment may *not* be billed to the MO HealthNet participant or the participant's guardian caretaker. In order for a copayment to be collected the parent, guardian or responsible party *must* also be the subscriber or policyholder on the insurance policy and *not* a MO HealthNet participant.

5.5 MEDICAL SUPPORT

It is common for courts to require (usually in the case of divorce or separation) that the noncustodial parent provide medical support through insurance coverage for their child(ren). Medical support is included on all administrative orders for child support established by the Family Support Division.

At the time the provider obtains MO HealthNet and third party resource information from the child's caretaker, the provider should ask whether this type of resource exists. Medical support is a primary resource.
If the third party resource is derived from a non-custodial parent whose medical support obligation is being enforced by the Family Support Division 42 CFR 433.139 (b)(3)requires the state Medicaid agency to pay and chase these claims when the provider has billed the TPR and been unable to obtain payment and 100 days have passed since the date of service. The provider must submit an attestation that all conditions have been met in order to receive payment.

By accepting MO HealthNet reimbursement, the provider gives up the right to collect any additional amounts due from the insurance resource. Federal regulation requires any excess amounts collected by the MO HealthNet agency be distributed to the participant/policyholder.

5.6 PROVIDER CLAIM DOCUMENTATION REQUIREMENTS

MO HealthNet is *not* responsible for payment of claims denied by the third party resource if all required forms were *not* submitted to the TPR, if the TPR's claim filing instructions were *not* followed, if the TPR needs additional information to process the claim or if any other payment precondition was *not* met. Post payment review of claims may be conducted to verify the validity of the insurance denial. The MO HealthNet payment amount is recovered if the denial is related to reasons noted above and MO HealthNet paid the claim. MO HealthNet's timely filing requirements are *not* extended due to difficulty in obtaining the necessary documentation from the third party resource for filing with MO HealthNet. Refer to Section 4 regarding timely filing limitations.

If the provider or participant is having difficulty obtaining the necessary documentation from the third party resource, the provider should contact Program Relations, (573) 751-2896, or the TPL Unit directly, (573) 751-2005, for further instructions. *Because difficulty in obtaining necessary TPR documentation does not extend MO HealthNet's timely filing limitations, please contact the TPL Unit or Provider Relations early to obtain assistance.*

5.6.A EXCEPTION TO TIMELY FILING LIMIT

The 12-month initial filing rule can be extended if a third party payer, after making a payment to a provider, being satisfied that the payment is proper and correct, later reverses the payment determination, sometimes after 12 months have elapsed, and requests the provider to return the payment. Because TPL was clearly available to cover the full amount of liability, and this was known to the provider, the provider may not have initially filed a

claim with the State agency. The problem occurs when the provider, after having repaid the third party, wishes to file the claim with MO HealthNet, and is unable to do so because more than 12 months have elapsed since the date of service. Under this set of circumstances, the provider may file a claim with the MO HealthNet agency later than 12 months from the date of service. The provider *must* submit this type of claim to the Third Party Liability Unit at P.O. Box 6500, Jefferson City, MO 65102-6500 for special handling.

5.6.B TPR CLAIM PAYMENT DENIAL

If the participant eligibility file indicates there is applicable insurance coverage relating to the provider's claim type and a third party payment amount is *not* indicated on the claim, or documentation is *not* attached to indicate a legitimate denial of payment by the insurance company, the claim is denied for MO HealthNet payment.

A legitimate denial is defined as an explanation of benefits from an insurance plan that clearly states that the submitted services are *not* payable for reasons other than failure to meet claim filing requirements. For instance, a denial from a TPR stating the service is *not* covered by the plan, exceeds usual and customary charges, or was applied to a deductible are all examples of legitimate denials. The MO HealthNet agency *must* be able to identify that the denial originated from the TPR and the reason for the denial is clearly stated. If the insurance company uses denial codes, be sure to include the explanation of that code. A handwritten note from the provider or from an unidentifiable source is *not* a legitimate denial.

The claim is denied if the "Other" accident box in Field #10 of the CMS-1500 claim form is marked and the eligibility file indicates there is an insurance coverage code of 40. MO HealthNet denies payment if the claim does *not* indicate insurance payment or there is no legitimate TPR denial attached to the claim. Do *not* mark this box unless the services are applicable to an accident.

To avoid unnecessary delay in payment of claims, it is extremely important to follow the claim completion instructions relating to third party liability found in the provider manual. Incorrect completion of the claim form may result in denial or a delay in payment of the claim.

5.7 THIRD PARTY LIABILITY BYPASS

There are certain claims that are *not* subjected to Third Party Liability edits in the MO HealthNet payment system. These claims are paid subject to all other claim submission requirements being met. MO HealthNet seeks recovery from the third party resource after MO HealthNet reimbursement has been made to the provider. If the third party resource reimburses MO HealthNet more than the maximum MO HealthNet allowable, by federal regulation this overpayment *must* be forwarded to the participant/policyholder.

The provider may choose *not* to pursue the third party resource and submit a claim to MO HealthNet. The provider's payment is limited to the maximum MO HealthNet allowable. The following services bypass Third Party Liability edits in the MO HealthNet claims payment system:

- The claim is for personal care or homemaker/chore services.
- The claim is for intellectually disabled/developmentally disabled (ID/DD) waiver services.
- The claim is related to preventative pediatric care.

5.8 MO HEALTHNET INSURANCE RESOURCE REPORT (TPL-4)

Many times a provider may learn of a change in insurance information prior to MO HealthNet as the provider has an immediate contact with their patients. If the provider learns of new insurance information or of a change in the TPL information, they may submit the information to the MO HealthNet agency to be verified and updated to the participant's eligibility file.

The provider may report this new information to the MO HealthNet agency using the MO HealthNet Insurance Resource Report. Complete the form as fully as possible to facilitate the verification of the information. Do *not* attach claims to process for payment. They *cannot* be processed for payment due to the verification process.

Please allow six to eight weeks for the information to be verified and updated to the participant's eligibility file. Providers wanting confirmation of the state's response should indicate so on the form and ensure the name and address information is completed in the spaces provided.

5.9 LIABILITY AND CASUALTY INSURANCE

Injuries resulting from an accident/incident (i.e., automobile, work-related, negligence on the part of another person) often place the provider in the difficult position of determining liability. Some situations may involve a participant who:

- is a pedestrian hit by a motor vehicle;
- is a driver or passenger in a motor vehicle involved in an accident;
- is employed and is injured in a work-related accident;
- is injured in a store, restaurant, private residence, etc., in which the owner may be liable.

The state monitors possible accident-related claims to determine if another party may be liable; therefore, information given on the claim form is very important in assisting the state in researching accident cases. 13 CSR 4.030 and 13 CSR 4.040 requires the provider to report the contingent liability to the MO HealthNet Division.

Often the final determination of liability is *not* made until long after the accident. In these instances, claims for services may be billed directly to MO HealthNet prior to final determination of liability; however, it is important that MO HealthNet be notified of the following:

- details of the accident (i.e., date, location, approximate time, cause);
- any information available about the liability of other parties;
- possible other insurance resources;
- if a lien was filed prior to billing MO HealthNet.

This information may be submitted to MO HealthNet directly on the claim form, by calling the TPL Unit, (573) 751-2005, or by completing the Accident Report. Providers may duplicate this form as needed.

5.9.A TPL RECOVERY ACTION

Accident-related claims are processed for payment by MO HealthNet. The Third Party Liability Unit seeks recovery from the potentially liable third party on a post-payment basis. Once MO HealthNet is billed, the MO HealthNet payment precludes any further recovery action by the provider. The MO HealthNet provider may *not* then bill the participant or his/her attorney.

5.9.B LIENS

Providers may *not* file a lien for MO HealthNet covered services after they have billed MO HealthNet. If a lien was filed prior to billing MO HealthNet, and the provider subsequently receives payment from MO HealthNet, the provider *must* file a notice of lien withdrawal for the covered charges with a copy of the withdrawal notice forwarded to:

MO HealthNet Division
Third Party Liability Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

5.9.C TIMELY FILING LIMITS

MO HealthNet timely filing rules are *not* extended past specified limits, if a provider chooses to pursue the potentially liable third party for payment. If a court rules there is no liability or the provider is *not* reimbursed in full or in part because of a limited settlement amount, the provider may *not* bill the participant for the amounts in question even if MO HealthNet's timely filing limits have been exceeded.

5.9.D ACCIDENTS WITHOUT TPL

MO HealthNet should be billed directly for services resulting from accidents that do *not* involve any third party liability or where it is probable that MO HealthNet is the only coverage available.

Examples are:

- An accidental injury (e.g., laceration, cut, broken bone) occurs as a result of the participant's own action.
- A MO HealthNet participant is driving (or riding in) an uninsured motor vehicle that is involved in a *one* vehicle accident and the participant or driver has no uninsured motorist insurance coverage.

If the injury is obviously considered to be "no-fault" then it should be clearly stated. *Providers must be sure to fill in all applicable blocks on the claim form concerning accident information.*

5.10 RELEASE OF BILLING OR MEDICAL RECORDS INFORMATION

The following procedures should be followed when a MO HealthNet participant requests a copy of the provider's billing or medical records for a claim paid by or to be filed with MO HealthNet.

- If an attorney is involved, the provider should obtain the full name of the attorney.
- In addition, the provider should obtain the name of any liable party, the liable insurance company name, address and policy number.
- Prior to releasing bills or medical records to the participant, the provider *must* either contact the MO HealthNet Division, Third Party Liability Unit, P.O. Box 6500, Jefferson City, MO 65102-6500, (573) 751-2005, or complete a MO HealthNet Accident Report or MO HealthNet Insurance Resource Report as applicable. If the participant requires copies of bills or medical records for a reason other than third party liability, it is *not* necessary to contact the Third Party Liability Unit or complete the forms referenced above.
- Prior to releasing bills or medical records to the participant, the provider *must* stamp or write across the bill, "Paid by MO HealthNet" or "Filed with MO HealthNet" in compliance with 13 CSR 70-3.040.

5.11 OVERPAYMENT DUE TO RECEIPT OF A THIRD PARTY RESOURCE

If the provider receives payment from a third party resource after receiving MO HealthNet reimbursement for the covered service, the provider *must* promptly submit an Individual Adjustment

Request form to MO HealthNet for the partial or full recovery of the MO HealthNet payment. The amount to be refunded *must* be the full amount of the other resource payment, *not* to exceed the amount of the MO HealthNet payment. Refer to Section 6 for information regarding adjustments.

5.12 THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

The Health Insurance Premium Payment (HIPP) Program is a MO HealthNet Program that pays for the cost of health insurance premiums for certain MO HealthNet participants. The program purchases health insurance for MO HealthNet-eligible participants when it is determined cost effective. Cost effective means that it costs less to buy the health insurance to cover medical care than to pay for the same services with MO HealthNet funds. The HIPP Program *cannot* find health insurance policies for MO HealthNet participants, rather it purchases policies already available to participants through employers, former employers, labor unions, credit unions, church affiliations, other organizations, or individual policies. Participants may voluntarily enroll in the program. Questions about the program can be directed to:

MO HealthNet Division
TPL Unit - HIPP Section
P.O. Box 6500
Jefferson City, MO 65102-6500

or by calling (573) 751-2005.

5.13 DEFINITIONS OF COMMON HEALTH INSURANCE TERMINOLOGY

COINSURANCE: Coinsurance is a percentage of charges for a specific service, which is the responsibility of the beneficiary when a service is delivered. For example, a beneficiary may be responsible for 20 percent of the charge of any primary care visits. MO HealthNet pays only up to the MO HealthNet allowable minus any amounts paid by the third party resource regardless of any coinsurance amount.

COMPREHENSIVE INSURANCE PLAN: The comprehensive plan is also sometimes called a wraparound plan. Despite the name, comprehensive plans do not supply coverage as extensive as that of traditional insurance. Instead these plans are labeled “comprehensive” because they have no separate categories of insurance coverage. A comprehensive plan operates basically like a full major medical plan, with per-person and per-family deductibles, as well as coinsurance requirements.

COPAYMENT: Copayments are fixed dollar amounts identified by the insurance policy that are the responsibility of the patient; e.g., $3 that a beneficiary must pay when they use a particular service or

services. MO HealthNet cannot reimburse copayment amounts. An insurance plan's copayment requirements should not be confused with the MO HealthNet cost sharing (copayment, coinsurance, shared dispensing fee) requirements established for specific MO HealthNet services.

DEDUCTIBLE: Deductibles are amounts that an individual must pay out-of-pocket before third party benefits are made available to pay health care costs. Deductibles may be service specific and apply only to the use of certain health care services, or may be a total amount that must be paid for all service use, prior to benefits being available. MO HealthNet pays only up to the MO HealthNet allowable regardless of the deductible amount.

FLEXIBLE BENEFIT OR CAFETERIA PLANS: Flexible benefit plans operate rather like a defined contribution pension plan in that the employer pays a fixed and predetermined amount. Employees generally share some portion of the plan's premium costs and thus are at risk if costs go up. Flexible benefit plans allow employees to pick what benefits they want. Several types of flexible programs exist, and three of the more popular forms include modular packages, core-plus plans, and full cafeteria plans.

Modular plans offer a set number of predetermined policy options at an equal dollar value but includes different benefits. Core-plus plans have a set "core" of employer-paid benefits, which usually include basic hospitalization, physician, and major medical insurance. Other benefit options, such as dental and vision, can be added at the employees' expense. Full cafeteria plans feature employer-paid "benefit dollars" which employees can use to purchase the type of coverage desired.

COMMERCIAL HEALTH CARE PLANS: Commercial health care plans generally provide full protection in that subscribers incur no additional expenses other than their premiums (and a copay charge if specified). These plans, however, limit the choice of hospitals and doctors.

Commercial health care plans come in two basic forms. The first type, sometimes referred to as a staff or group model health maintenance organization, encompasses the traditional HMO model used by organizations like Kaiser Permanente or SANUS. The physicians are salaried employees of the HMO, and a patient's choice of doctors is often determined by who is on call when the patient visits.

The second type of health care plan is known as an individual (or independent) practice association (IPA) or a preferred provider organization (PPO), each of which is a network of doctors who work individually out of their own offices. This arrangement gives the patient some degree of choice within the group. If a patient goes outside the network, however, the plan reimburses at a lower percentage. Generally an IPA may be prepaid, while a PPO is similar to a traditional plan, in that claims may be filed and reimbursed at a predetermined rate if the services of a participating doctor are utilized. Some IPAs function as HMOs.

SELF-INSURANCE PLANS: An alternative to paying premiums to an insurance company or managed-care plan is for an employer to self-insure. One way to self-insure is to establish a section 501(c)(9) trust, commonly referred to as a VEBA (Voluntary Employee Benefit Association). The

VEBA must represent employees' interest, and it may or may not have employee representation on the board. It is, in effect, a separate entity or trust devoted to providing life, illness, or accident benefits to members.

A modified form of self-insurance, called minimum premium, allows the insurance company to charge only a minimum premium that includes a specified percentage of projected annual premiums, plus administrative and legal costs (retention) and a designated percentage of the annual premium. The employer usually holds the claim reserves and earns the interest paid on these funds.

Claims administration may be done by the old insurance carrier, which virtually guarantees replication of the former insurance program's administration. Or the self-insurance program can be serviced through the employer's own benefits office, an option commonly employed by very large companies of 10,000 or more employees. The final option is to hire an outside third-party administrator (TPA) to process claims.

TRADITIONAL INSURANCE PLAN: Provides first-dollar coverage with usually three categories of benefits: (1) hospital, (2) medical/surgical, and (3) supplemental major medical, which provides for protection for medical care not covered under the first two categories. Variations and riders to these plans may offer coverage for maternity care, prescription drugs, home and office visits, and other medical expenses.

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SECTION 6-ADJUSTMENTS

6.1 GENERAL REQUIREMENTS

MO HealthNet Division (MHD) continues to improve their billing website at www.emomed.com to provide real-time direct access for administrators, providers, and clearinghouse users. This describes the process and tools providers should use to adjust claims.

6.2 INSTRUCTIONS FOR ADJUSTING CLAIMS WITHIN 24 MONTHS OF DATE OF SERVICE

MHD developed an easy to use, web-based tool to adjust incorrectly billed and/or paid Medicaid and Medicare crossover claims. Providers shall utilize the web-based adjustment tool to adjust or void their own claims, if the date of service (DOS) on the claim to be adjusted was within two (2) years of the date of the Remittance Advise on which payment was made.

6.2.A NOTE: PROVIDERS MUST BE ENROLLED AS AN ELECTRONIC BILLING PROVIDER BEFORE USING THE ONLINE CLAIM ADJUSTMENT TOOL

Providers *must* be enrolled as an electronic billing provider before using the online claim adjustment tool. See Section 2.1.D.

To apply for Internet access, please access the emomed website found on the following website address: www.emomed.com. Access the "Register Now!" hyperlink to apply online for Internet access and follow the instructions provided. Providers must have proper authorization to access www.emomed.com, for each individual user.

6.2.B ADJUSTING CLAIMS ONLINE

Providers may adjust claims within two (2) years of the DOS, by logging onto the MHD billing site at www.emomed.com. To find the claim to be adjusted, the provider should enter the participant Departmental Client Number (DCN) and DOS in the search box, and choose the highlighted Internal Control Number (ICN). Paid claims can be adjusted by the "Void" option or "Replacement" option. Denied claims can be adjusted by the "Copy Claim Original" or Copy Claim Advanced" option.

6.2.B(1) Options for Adjusting a Paid Claim

If there is a paid claim in the MHD emomed system, then the claim can be voided or replaced.

The provider should choose "Void" to delete a paid claim. A voided claim credits the system and reverses the payment. A void option should be chosen when the entire claim needs to be canceled and the payment is reversed and credited in the system. Providers do not void claims often because this option is only chosen when a claim should not have been submitted. This includes when the wrong DCN or billing Nations Provider Identifier (NPI) was entered on the claim.

The provider should choose "Replacement" to make corrections or additions to a paid claim. A replacement option should be chosen when editing a paid claim. Providers will use this option more often than the void option because the claim was billed incorrectly. This includes when the wrong DOS, diagnosis, charge amount, modifier, procedure code, or POS was entered on the claim.

6.2.B(1)(i) Void

To void a claim from the claim status screen on emomed, choose the void tab. This will bring up the paid claim in the system; scroll to the bottom of the claim and chose select the highlighted 'submit claim' button. The claim now has been submitted to be voided or credited in the system.

6.2.B(1)(ii) Replacement

To replace a claim from the claim status screen on emomed, choose the replacement tab. This will bring up the paid claim in the system; here corrections can be made to the claim by selecting the appropriate edit button, then saving the changes. Now scroll to the bottom of the claim and select the highlighted 'submit claim' button. The replacement claim with corrections has now been submitted.

6.2.B(2) Options for Adjusting a Denied Claim

If there is a denied claim in the MHD emomed system, then the claim can be resubmitted as a New Claim. A denied claim can also be resubmitted by choosing Timely Filing, Copy Claim-original, or Copy Claim-advanced.

6.2.B(2)(i) Timely Filing

To reference timely filing, choose the Timely Filing tab on the claim status screen on emomed. This function automatically places the ICN of the claim chosen (make sure the claim was the original claim submitted within the timely filing guidelines). Scroll to the bottom and select the highlighted 'submit claim' button. The claim has now been submitted for payment.

6.2.B(2)(ii) Copy Claim – Original

This option is used to copy a claim just as it was entered originally on emomed. Corrections can be made to the claim by selecting the appropriate edit button, and then saving the changes. Now scroll to the bottom of the claim and select the highlighted submit claim button. The claim has now been submitted with the corrections made.

6.2.B(2)(iii) Copy Claim – Advanced

This option is used when the claim was filed using the wrong NPI number or wrong claim form. An example would be if the claim was entered under the individual provider NPI and should have been submitted under the group provider NPI. If the claim was originally filed under the wrong claim type, only the participant DCN and Name information will transfer over to the new claim type. An example would be if the claim was submitted on a Medical claim and should have been submitted as a Crossover claim.

6.2.C CLAIM STATUS CODES

After the adjusted claim is submitted, the claim will have one of the following status indicator codes.

C – This status indicates that the claim has been Captured and is still processing. This claim should not be resubmitted until it has a status of I or K.

I – This status indicates that the claim is to be Paid.

K – This status indicates that the claim is to be Denied. This claim can be corrected and resubmitted immediately.

Provider Communications Unit may be contacted at (573) 751-2896, for questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verifications. Please contact Provider Education Unit at (573) 751-6683 or email mhd.provtrain@dss.mo.gov for education and training on proper billing methods and procedures for MHD claims.

6.3 INSTRUCTIONS FOR ADJUSTING CLAIMS OLDER THAN 24 MONTHS OF DOS

Providers who are paid incorrectly for a claim that is older than 24 months are required to complete a Self-Disclosure letter to be submitted to Missouri Medicaid Audit and Compliance (MMAC). Access the MMAC website for the Self-Disclosure Form located at the following website address: http://mmac.mo.gov/providers/self-audits-Self-Disclosures/.

MMAC encourages providers and entities to establish and implement a compliance integrity plan. MMAC also encourages providers and entities to self-disclose or report those findings along with funds to compensate for the errors or a suggested repayment plan, which requires MMAC approval, to the Financial Section of MMAC at the address below:

Missouri Medicaid Audit & Compliance
Financial Section – SELF-DISCLOSURE
P.O. Box 6500
Jefferson City, MO 65102-6500

In an effort to ensure Provider Initiated Self-Disclosures are processed efficiently, make sure to complete the form and include the participant's name, DCN, DOS, ICN, Paid Amount, Refund Amount and Reason for Refund. Providers can direct questions regarding Self-Disclosures to MMAC Financial Section at mmac.financial@dss.mo.gov or by calling 573-751-3399.

6.4 EXPLANATION OF THE ADJUSTMENT TRANSACTIONS

There are two (2) types of adjustment transactions:

1. An adjustment that credits the original payment and then repays the claim based on the adjusted information appears on the Remittance Advice as a two-step transaction consisting of two ICN's.
    - An ICN that credits (recoups) the original paid amount and
    - An ICN that repays the claim with the corrected payment amount.
2. An adjustment that credits or recoups the original payment but does not repay the claim (resulting in zero payment) appears on the Remittance Advice with one ICN that credits (recoups) the original paid amount.

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SECTION 7-MEDICAL NECESSITY

7.1 CERTIFICATE OF MEDICAL NECESSITY

The MO HealthNet Program requires that the Certificate of Medical Necessity form accompany claims for reimbursement of certain procedures, services or circumstances. Section 13, Benefits and Limitations, identifies circumstances for which a Certificate of Medical Necessity form is required for each program. Additional information regarding the use of this form may also be found in Section 14, Special Documentation Requirements.

Listed below are several examples of claims for payment that *must* be accompanied by a completed Certificate of Medical Necessity form. This list is *not* all inclusive.

- Claims for services performed as emergency procedures which, under non-emergency circumstances, require special documentation such as a Prior Authorization Request.
- Claims for inpatient hospital private rooms unless all patient rooms in the facility are private.
- Claims for services for TEMP participants that are *not* covered by the TEMP Program but without which the pregnancy would be adversely affected.
- Claims for specific durable medical equipment.

Use of this form for other than the specified conditions outlined in the provider's manual has *no* bearing on the payment of a claim.

The medical reason why the item, service, or supplies were needed *must* be stated fully and clearly on the Certificate of Medical Necessity form. The form *must* be related to the particular patient involved and *must* detail the risk to the patient if the service(s) had *not* been provided.

The Certificate of Medical Necessity form *must* be either submitted electronically with the electronic claim or submitted on paper attached to the original claim form. For information regarding submission of the Certificate of Medical Necessity for claims submitted by a Durable Medical Equipment provider see Section 7.1.A. If a claim is resubmitted, the provider *must* again attach a copy of the Certificate of Medical Necessity form.

Medical consultants and medical review staff review the Certificate of Medical Necessity form and the claim form to make a determination regarding payment of the claim. If the medical necessity of the service is supported by the documentation, the claim is approved for further processing. If medical necessity is *not* documented or supported, the claim is denied for payment.

7.1.A CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS

The Certificate of Medical Necessity for durable medical equipment should *not* be submitted with a claim form. This attachment may be submitted via the Internet (see Section 3.8 and Section 23) or mailed to:

Wipro Infocrossing
P.O. Box 5900
Jefferson City, MO 65102-5900

If the Certificate of Medical Necessity is approved, the approved time period is six (6) months from the prescription date. Any claim matching the criteria (including the type of service) on the Certificate of Medical Necessity for the approved time period can be processed for payment without a Certificate of Medical Necessity attached. This includes all monthly claim submissions and any resubmissions.

7.2 INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1. Patient Name	Enter last name, first name and middle initial as shown on the ID card.
2. Participant MO HealthNet ID Number	Enter the 8-digit MO HealthNet ID number exactly as it appears on the participant's ID card or letter of eligibility.
3. Procedure/Revenue Codes	Enter the appropriate CPT-4 code, CDT-3 code, revenue code or HCPCS procedure code (maximum of 6 procedure/revenue codes allowed per claim, 1 code per line).
4. Description of Item/Service	For each procedure/revenue code listed, describe in detail the service or item being provided.
5. Reason for Service	For each procedure/revenue code listed, state clearly the medical necessity for this service/item.

6. Months Item Needed (DME only)	For each procedure code listed, enter the amount of time the item is necessary (Durable Medical Equipment Program only).
7. Name and Signature of Prescriber	The prescriber's signature, when required, *must* be an original signature. A stamp or the signature of a prescriber's employee is *not* acceptable. A signature is *not* required here if the prescriber is the provider (Fields #12 thru #14).
8. Prescriber's MO HealthNet Provider Identifier	Enter the NPI number if the prescriber participates in the MO HealthNet Program.
9. Date Prescribed	Enter the date the service or item was prescribed or identified by the prescriber as medically necessary in month/date/year numeric format, if required by program. This date *must* be prior to or equal to the date of service.
10. Diagnosis	Enter the appropriate ICD code(s) that prompted the request for this service or item, if required by program.
11. Prognosis	Enter the participant's prognosis and the anticipated results of the requested service or item.
12. Provider Name and Address	Enter provider's name, address, and telephone number.
13. MO HealthNet Provider Identifier	Enter provider's NPI number.
14. Provider Signature	The provider *must* sign here with an original signature. This certifies that the information given on the form is true, accurate and complete.

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SECTION 8-PRIOR AUTHORIZATION

8.1 BASIS

Under the MO HealthNet Program, certain covered services and equipment require approval prior to provision of the service as a condition of reimbursement. Prior authorization is used to promote the most effective and appropriate use of available services and to determine the medical necessity of the service.

A prior authorization or precertification determines medical necessity of service(s) provided to the participant. It does *not* guarantee payment nor does it guarantee participant eligibility.

A prior authorization or precertification determines the number of units, hours and/or the types of services that may be provided to a participant based on the medical necessity of that service. The provider should *not* submit claims solely on the basis of the prior authorization and/or precertification, but *must* submit claims upon actual services rendered. Providers *must* retain the appropriate documentation that services were provided on the date of service submitted on the claim. Documentation should be retained for five (5) years.

Please refer to Sections 13 and 14 of the applicable provider manual for program-specific information regarding prior authorization.

8.2 PRIOR AUTHORIZATION GUIDELINES

Providers are required to seek prior authorization for certain specified services *before* delivery of the services. In addition to services that are available through the traditional MO HealthNet Program, expanded services are available to children 20 years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization. Certain services require prior authorization only when provided in a specific place or when they exceed certain limits. These limitations are explained in detail in Sections 13 and 14 of the applicable provider manuals.

The following general guidelines pertain to all prior authorized services:

- A Prior Authorization (PA) Request *must* be completed and mailed to the appropriate address. Unless otherwise specified in Sections 13 and 14 of the applicable provider manual, mail requests to:

  Wipro Infocrossing
  P.O. Box 5700
  Jefferson City, MO 65102-5700

  A PA Request form may be printed and completed by hand or the form may be completed in Adobe and then printed. To enter information into a field, either click in the field or tab to the

field and complete the information. When all the fields are completed, print the PA Request and send to the address listed above.

- The provider performing the service *must* submit the PA Request form. Sufficient documentation or information *must* be included with the request to determine the medical necessity of the service.
- The service *must* be ordered by a physician, nurse practitioner, dentist, or other appropriate health care provider.
- Do *not* request prior authorization for services to be provided to an ineligible person (see Sections 1 and 13 of the applicable provider manual).
- Expanded HCY (EPSDT) services are limited to participants 20 years of age and under and are *not* reimbursed for participants 21 and over even if prior authorized.
- See Section 20 for specific criteria and guidelines regarding prior authorization of non-covered services through the Exceptions Process for participants 21 and over.
- Prior authorization does *not* guarantee payment if the participant is or becomes enrolled in managed care and the service is a covered benefit.
- Payment is *not* made for services initiated before the approval date on the PA Request form or after the authorization deadline.
- For services to continue after the expiration date of an existing PA Request, a new PA Request *must* be completed and submitted prior to the end of the current PA.

8.3 PROCEDURE FOR OBTAINING PRIOR AUTHORIZATION

Complete the Prior Authorization (PA) Request form describing in detail those services or items requiring prior authorization and the reason the services or items are needed. With the exception of x-rays, dental molds, and photos, documentation submitted with the PA Request is *not* returned. Providers should retain a copy of the original PA Request and any supporting documentation submitted for processing. Instructions for completing the PA Request form are on the back of the form. *Unless otherwise stated in Section 13 or 14 of the applicable provider manual,* mail the PA Request form and any required attachments to:

Wipro Infocrossing
P.O. Box 5700
Jefferson City, Missouri 65102-5700

The appropriate program consultant reviews the request. A MO HealthNet Authorization Determination is returned to the provider with any stipulations for approval or reason for denial. If approved, services may *not* exceed the frequency, duration or scope approved by the consultant. If the service or item requested is to be manually priced, the consultant enters the allowed amount on the MO HealthNet

Authorization Determination. The provider should keep the approved MO HealthNet Authorization Determination for their files; do *not* return it with the claim.

After the authorized service or item is provided, the claim form *must* be completed and submitted in the usual manner. **Providers are cautioned that an approved authorization approves only the medical necessity of the service and does *not* guarantee payment. Claim information *must* still be complete and correct, and the provider and the participant *must* both be eligible at the time the service is rendered or item delivered. Program restrictions such as age, category of assistance, managed care, etc., that limit or restrict eligibility still apply and services provided to ineligible participants are *not* reimbursed.**

If the PA Request is denied, the provider receives a MO HealthNet Authorization Determination (reference Section 8.7 of this manual). The participant is notified by letter each time a PA Request is denied. (Reference Section 1 of this manual for additional information regarding the PA Request Denial letter.)

8.4 EXCEPTIONS TO THE PRIOR AUTHORIZATION REQUIREMENT

Exceptions to prior authorization requirements are limited to the following:

- Medicare crossovers when Medicare makes the primary reimbursement and MO HealthNet pays only the coinsurance and deductible.
- Procedures requiring prior authorization that are performed incidental to a major procedure.
- Services performed as an emergency. An emergency medical condition for a MO HealthNet participant means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

    1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
    2. Serious impairment of bodily functions; or
    3. Serious dysfunction of any bodily organ or part; or
    4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
    5. Injury to self or bodily harm to others; or
    6. With respect to a pregnant woman having contractions: (a) there is no adequate time to affect a safe transfer to another hospital before delivery; or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

In the case of an emergency when prior authorization *cannot* be obtained before the service or item is rendered, the necessary and appropriate emergency service should be provided. Complete the claim form and write "emergency" across the top of the claim form. Do *not* submit a Prior Authorization (PA) Request form.

Attach a Certificate of Medical Necessity form to the claim and submit it to the appropriate address (reference Section 15). The provider *must* state on the Certificate of Medical Necessity form, in detail, the reason for the emergency provision of service. (See Section 7 for information on completing a Certificate of Medical Necessity form.)

Emergency requests are suspended and reviewed by the appropriate medical consultant. If the Certificate of Medical Necessity form is *not* attached or the reason does *not* substantiate the provision of the service on an emergency basis, the claim is denied.

- The participant was *not* eligible for MO HealthNet at the time of service, but eligibility was made retroactive to that time. Submit a claim along with a Certificate of Medical Necessity form to the appropriate address (reference Section 15). The provider *must* state on the Certificate of Medical Necessity form that the participant was *not* eligible on the date of service, but has become eligible retroactively to that date. The provider *must* also include, in detail, the reason for the provision of service. (See Section 7 for information on completing a Certificate of Medical Necessity form.) Retroactive eligibility requests are suspended and reviewed by the appropriate medical consultant. If the Certificate of Medical Necessity form is *not* attached or the reason does *not* substantiate the provision of the service, the claim is denied.

8.5 INSTRUCTIONS FOR COMPLETING THE PRIOR AUTHORIZATION (PA) REQUEST FORM

Instructions for completing the Prior Authorization (PA) Request form are printed on the back of the form. Additional clarification is as follows:

- Section II, HCY Service Request, is applicable for participants 20 years of age and under and should be completed when the information is known.
- In Section III, Service Information, the gray area is for state use only.

  Field #24 in Section III, in addition to being used to document medical necessity, can also be used to identify unusual circumstances or to provide detailed explanations when necessary. Additional pages may be attached to the PA Request for documentation.

Also, the PA Request forms *must* reflect the appropriate service modifier with procedure code and other applicable modifiers when requesting prior authorization for the services defined below:

Service Modifier	Definition
26	Professional Component
54	Surgical Care Only
55	Postoperative Management Only
80	Assistant Surgeon
AA	Anesthesia Service Performed Personally by Anesthesiologist
NU	New Equipment (required for DME service)
QK	Medical Direction of 2, 3, or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals
QX	CRNA (AA) Service; with Medical Direction by a Physician
QZ	CRNA Service; without Medical Direction by a Physician
RB	Replacement and Repair (required for DME service)
RR	Rental (required for DME service)
SG	Ambulatory Surgical Center (ASC) Facility Services
TC	Technical Component

- Complete each field in Section IV. See Sections 13 and 14 of the applicable provider manual to determine if a signature and date are required in this field. Requirements for signature are program specific.
- Section V, Prescribing/Performing Practitioner, *must* be completed for services which require a prescription such as durable medical equipment, physical therapy, or for services which are prescribed by a physician/practitioner that require prior authorization. Reference the applicable provider manual for additional instructions.

The provider receives a MO HealthNet Authorization Determination (refer to Section 8.6) indicating if the request has been approved or denied. Any comments made by the MO HealthNet/MO HealthNet managed care health plan consultant may be found in the comments section of the MO HealthNet Authorization Determination. The provider does *not* receive the PA Request or a copy of the PA Request form back.

It is the provider's responsibility to request prior authorization or reauthorization, and to notify the MO HealthNet Division of any changes in an existing period of authorization.

8.5.A WHEN TO SUBMIT A PRIOR AUTHORIZATION (PA) REQUEST

Providers may submit a Prior Authorization (PA) Request to:

- Initiate the start of services that require prior authorization.

- Request continued services when services continue to be medically necessary beyond the current approved period of time.
  1. The dates for the services requested *cannot* overlap dates that are already approved and *must* be submitted far enough in advance to obtain approval prior to the expiration of the current approved PA Request.
- Correct a participant MO HealthNet number if the original PA Request had a number on it and services were approved.
  1. When submitting a PA Request due to an error in the participant MO HealthNet number on the original PA Request, attach a copy of the MO HealthNet Authorization Determination giving original approval to the new request.
  2. Fields #17 through #23 in Section III *must* be identical to the original approval.
  3. The PA Request form should be clearly marked as a "correction of the participant MO HealthNet number" and the error *must* be explained in detail in Field #24 of Section III.
  4. Mark the PA Request *"Special Handle"* at the top of the form.
- Change providers within a group during an approved authorization period.
  1. When submitting a PA Request due to a change of provider *within a group,* attach a copy of the MO HealthNet Authorization Determination showing the approval to the new PA Request form.
  2. Section III, Field #19 "FROM" *must* be the date the new provider begins services and Field 20 "THROUGH" *cannot* exceed the through date of the previously approved PA Request.
  3. The PA Request form should be clearly marked at the top "change of provider," and the change *must* be explained in Field #24 of Section III.
  4. Mark the PA Request "*Special Handle"* at the top of the form. Use Field #24 to provide a detailed explanation.

8.6 MO HEALTHNET AUTHORIZATION DETERMINATION

The MO HealthNet Authorization Determination is sent to the provider who submitted the Prior Authorization (PA) Request. The MO HealthNet Authorization Determination includes all data pertinent to the PA Request. The MO HealthNet Authorization Determination includes the PA number; the authorized National Provider Identifier (NPI); name and address; the participant's DCN, name, and date of birth; the procedure code, the from and through dates (if approved), and the units or dollars (if approved); the status of the PA Request on each detail line ("A"-approved; "C"-closed; "D"-denied; and "I"-incomplete); and the applicable Explanation of Benefit (EOB) reason(s), with the reason code description(s) on the reverse side of the determination.

8.6.A A DENIAL OF PRIOR AUTHORIZATION (PA) REQUESTS

The MO HealthNet Authorization Determination indicates a denied authorization by reflecting a status on each detail line of "D" for a denial of the requested service or "I" for a denial due to incomplete information on the form. With a denial status of "D" or "I", a new PA Request form *must* be submitted for the request to be reconsidered.

8.6.B MO HEALTHNET AUTHORIZATION DETERMINATION EXPLANATION

The following lists the fields found on the MO HealthNet Authorization Determination and an explanation of each field.

FIELD NAME	EXPLANATION OF FIELD
Date	Date of the disposition letter
Request Number (No.)	Prior Authorization Number
Receipt Date	Date the Prior Authorization (PA) Request was received by the fiscal agent
Service Provider	Authorized NPI number, name and address
Participant	Participant's DCN, name, date of birth and sex
Procedure Code	The procedure code
Modifier	The modifier(s)
Authorization Dates	The authorized from and thru dates
Units	The units requested, units authorized (if approved), units used
Dollars	The dollar amount requested, dollar amount authorized (if approved), dollar amount used
Status	The status codes of the PA Request The status codes are: A—Approved C—Closed D—Denied I—Incomplete
Reason	The applicable EOB reason(s)
Comments	Comments by the consultant which may explain denials or make notations referencing specific procedure code(s)
Physician/Provider Signature	Signature of provider when submitting a Request for Change

	(RFC)
Date	Date of provider's signature when submitting a RFC
Reason Code Description	Reason code description(s) listed in Reason field

8.7 REQUEST FOR CHANGE (RFC) OF PRIOR AUTHORIZATION (PA) REQUEST

To request a change to an approved Prior Authorization (PA) Request, providers are required to make the applicable changes on the MO HealthNet Authorization Determination. Attach additional documentation per program requirement if the requested change is in frequency, amount, duration or scope or if it documents an error on the original request, e.g., plan of care, physician orders, etc. The amended MO HealthNet Authorization Determination *must* be signed and dated and submitted with applicable documentation to the address below. When changes to an approved PA Request are made on the MO HealthNet Authorization Determination, the MO HealthNet Authorization Determination is referred to as a Request For Change (RFC). **Requests for reconsideration of any detail lines that reflect a "D" or "I" status *must not* be included on a RFC. Providers *must* submit a new PA Request form for reconsideration of denied detail lines.**

When a RFC is approved, a MO HealthNet Authorization Determination incorporating the requested changes is sent to the provider. When a RFC is denied, the MO HealthNet Authorization Determination sent to the provider indicates the same information as the original MO HealthNet Authorization Determination that notified the provider of approval, with an Explanation of Benefit (EOB) stating that the requested changes were considered but were *not* approved.

Providers *must not* submit changes to PA Requests until the MO HealthNet Authorization Determination from the initial request is received.

Unless otherwise stated in Section 13 or 14 of the applicable provider manual, PA Request forms and RFCs should be mailed to:

Wipro Infocrossing
P. O. Box 5700
Jefferson City, MO 65102

8.7.A WHEN TO SUBMIT A REQUEST FOR CHANGE

Providers may submit a Request For Change to:

- Correct a procedure code.
- Correct a modifier.
- Add a new service to an existing plan of care.
- Correct or change the "from" or "through" dates.

1. The “from” date may *not* precede the approval date on the original request unless the provider can provide documentation that the original approval date was incorrect.
2. The “through” date *cannot* be extended beyond the allowed amount of time for the specific program. In most instances extending the end date to the maximum number of days allowed requires additional information or documentation.

- Increase or decrease requested units or dollars.
  1. An increase in frequency and or duration in some programs require additional or revised information.
- Correct the National Provider Identifier (NPI). The NPI number can only be corrected if both of the following conditions are met:
  - The number on the original request is in error; and
  - The provider was *not* reimbursed for any units on the initial Prior Authorization Request.
- Discontinue services for a participant.

8.8 DEPARTMENT OF HEALTH AND SENIOR SERVICES (DHSS)

Prior Authorization (PA) Requests and Requests For Change (RFC) for the Personal Care and Home Health Programs' services for children under the age of 21 *must* be submitted to Department of Health and Senior Services (DHSS), Bureau of Special Health Care Needs (BSHCN) for approval consideration. The BSHCN submits the request to Wipro Infocrossing. The BSHCN staff continues to complete and submit PA Requests and RFCs for Private Duty Nursing and Medically Fragile Adult waiver services.

PA Requests and RFCs for AIDS Waiver and Personal Care Programs' services for individuals with HIV/AIDS continue to be completed and submitted by the DHSS, Bureau of HIV, STD and Hepatitis contract case management staff.

All services authorized by the DHSS, Division of Senior and Disability Services (DSDS) or it’s designee, are authorized utilizing the Home and Community Based Services (HCBS) Web Tool, a component of the Department of Social Services, MO HealthNet Division’s Cyber Access system.

Please reference the provider manual for further information.

8.9 OUT-OF-STATE, NON-EMERGENCY SERVICES

All non-emergency, MO HealthNet-covered services that are to be performed or furnished out of state for eligible MO HealthNet participants and for which MO HealthNet is to be billed, *must* be prior

authorized before the services are provided. Services that are *not* covered by the MO HealthNet Program are *not* approved.

Out of state is defined as *not* within the physical boundaries of the state of Missouri or within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the state of Missouri.

A PA Request *form* is *not* required for out-of-state non-emergency services. To obtain prior authorization for out-of-state, non-emergency services, *a written request must* be submitted by a physician to:

MO HealthNet Division
Participant Services Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

The request may be faxed to (573) 526-2471.

The written request *must* include:

1. A brief past medical history;
2. Services attempted in Missouri;
3. Where the services are being requested and who will provide them; and
4. Why services can't be performed in Missouri.

NOTE: The out-of-state medical provider *must* agree to complete an enrollment application and accept MO HealthNet reimbursement. Prior authorization for out-of-state services expires 180 days from the date the specific service was approved by the state.

8.9.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION REQUESTS

The following are exempt from the out-of-state prior authorization requirement:

1. All Medicare/MO HealthNet crossover claims;
2. All foster care children living outside the state of Missouri. However, non-emergency services that routinely require prior authorization continue to require prior authorization by out-of-state providers even though the service was provided to a foster care child;
3. Emergency ambulance services; and
4. Independent laboratory services.

END OF SECTION

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SECTION 9-HEALTHY CHILDREN AND YOUTH PROGRAM

9.1 GENERAL INFORMATION

The Healthy Children and Youth (HCY) Program in Missouri is a comprehensive, primary and preventive health care program for MO HealthNet eligible children and youth under the age of 21 years. The program is also known as Early Periodic Screening, Diagnostic and Treatment (EPSDT). The Social Security Act authorizes Medicaid coverage of medical and dental services necessary to treat or improve defects and physical and mental/behavioral health conditions identified by an HCY screen. These services are covered by Medicaid regardless of whether the services are covered under the state Medicaid plan. Services identified by an HCY screening that are beyond the scope of the Medicaid state plan may require a plan of care identifying the treatment needs of the child with regard to amount, duration, scope, and prognosis. Prior authorization (PA) of services may be required for service needs and for services of extended duration. Reference Section 13, Benefits and Limitations, for a description of requirements regarding the provision of services.

The HCY Program works to equip MO HealthNet providers with the necessary tools and knowledge to carry out preventive services appropriate to the American Academy of Pediatrics' standard for pediatric preventive health care, Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents. Information about Bright Futures screening services can be found on their website at: https://brightfutures.aap.org/clinical-practice/Pages/default.aspx.

Every applicant under age 21 (or his or her legal guardian) is informed of the HCY Program by the Family Support Division income-maintenance Eligibility Specialists at the initial application for assistance. The participant is reminded of the HCY Program at each annual redetermination review.

The goal of the MO HealthNet Division is to have a health care home for each child—that is, to have a primary care provider who manages a coordinated, comprehensive, continuous health care program to address the child's health needs. The health care home should follow the screening periodicity schedule, perform interperiodic screens when medically necessary, and coordinate the child's specialty needs.

9.2 PLACE OF SERVICE (POS)

A full or partial HCY screen may be provided in the following places of service (POS):

03 School
11 Office
12 Home
19 Off Campus Outpatient Hospital
21 Inpatient Hospital
22 On Campus Outpatient Hospital

25 Birthing Center
71 State or Local Public Health Clinic
72 Rural Health Clinic
99 Other

9.3 DIAGNOSIS CODE

The Early Periodic Screening diagnosis code *must* appear as the primary diagnosis on a claim form submitted for HCY screening services.

The appropriate HCY screening procedure code should be used for the initial HCY screen and all other full or partial screens.

9.4 INTERPERIODIC SCREENS

Medically necessary screens outside the periodicity schedule that do *not* require the completion of all components of a full screen may be provided as an interperiodic screen or as a partial screen. An interperiodic screen has been defined by the Centers for Medicare & Medicaid Services (CMS) as any encounter with a health care professional acting within his or her scope of practice. This screen may be used to initiate expanded HCY services. Providers who perform interperiodic screens may use the appropriate level of Evaluation/Management visit (CPT) procedure code, the appropriate partial HCY screening procedure code, or the procedure codes appropriate for the professional's discipline as defined in their provider manual. Office visits and full or partial screenings that occur on the same day by the same provider are *not* covered unless the medical necessity is clearly documented in the participant's record. The diagnosis for the medical condition necessitating the interperiodic screening *must* be entered in the primary diagnosis field, and the appropriate screening diagnosis should be entered in the secondary diagnosis field.

The interperiodic screen does *not* eliminate the need for full HCY screening services at established intervals based on the child's age.

If not all components of the full or unclothed physical are met, the Reduced Preventive Screening codes *must* be billed.

PROCEDURE CODE	DESCRIPTION
99381 - 99385	Preventive Screen; new patient
99391 - 99395	Preventive Screen; established patient

9.5 FULL HCY/EPSDT SCREEN

PROCEDURE CODE	DESCRIPTION

99381EP-99385EP Full Medical Screening

99391EP-99395EP

99381EPUC-99385EPUC Full Medical Screening with Referral
99391EPUC-99395EPUC

A full HCY/EPSDT screen includes the following:

- A comprehensive unclothed physical examination;
- A comprehensive health and developmental history including assessment of both physical and mental/behavioral health development;
- Health education (including anticipatory guidance);
- Appropriate immunizations according to age;*
- Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated);*
- Lead screening according to established guidelines;
- Hearing screening;
- Vision screening; and
- Dental screening.

It is *not* always possible to complete all components of the full medical HCY screening service. For example, immunizations may be medically contraindicated or refused by the parent/guardian. The parent/guardian may also refuse to allow their child to have a lead blood level test performed. When the parent/guardian refuses immunizations or appropriate lab tests, the provider should attempt to educate the parent/guardian with regard to the importance of these services. If the parent/guardian continues to refuse the service the child's medical record *must* document the reason the service was *not* provided. Documentation may include a signed statement by the parent/guardian that immunizations, lead blood level tests, or lab work was refused. By fully documenting in the child's medical record the reason for *not* providing these services, the provider may bill a full medical HCY screening service even though all components of the full medical HCY screening service were *not* provided.

It is mandatory that the provider document in the patient's medical record that a preventive screening was provided. The provider can document the screenings in an electronic medical record, written medical record, or use the Bright Futures screening forms. Whether written or electronic, the record must contain all of the components of a full HCY screening.

The Title XIX participation agreement requires that providers maintain adequate fiscal and medical records that fully disclose services rendered, that they retain these records for 5 years, and that they make them available to appropriate state and federal officials on request. Providers *must* document the screening in the medical record if billing a screening.

The MO HealthNet Division is required to record and report to the Centers for Medicare & Medicaid Services all HCY screens and referrals for treatment. Reference Sections 13 and 15 for billing instructions. *Claims for the full medical screening and/or full medical screening with referral should be submitted promptly within a maximum of 60 days from the date of screening.*

Office Visits and HCY screenings in which an abnormality or a preexisting problem are addressed in the process of performing the preventive medicine evaluation and management (E/M) service are not billable on the same date of service.

An exception would be if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service. Diagnosis codes must clearly reflect the abnormality or condition for which the additional follow-up care or treatment is indicated. In addition, the medical necessity must be clearly documented in the participant's record, and the Certificate of Medical Necessity form must be fully completed and attached to the claim when submitting for payment.

If an insignificant or trivial problem/abnormality is encountered in the process of performing the preventive medicine E/M service, which does not require significant, additional work and the performance of the key components of a problem-oriented E/M service is not documented in the record, then an additional E/M service should not be reported separately.

*Reimbursement for immunizations and laboratory procedures is *not* included in the screening fee and may be billed separately.

9.5.A QUALIFIED PROVIDERS

The full screen *must* be performed by a MO HealthNet enrolled physician, assistant physician, physician assistant, nurse practitioner or nurse midwife*.

*only infants age 0-2 months; and females age 15-20 years

9.6 PARTIAL HCY/EPSDT SCREENS

Segments of the full medical screen may be provided by different providers. The purpose of this is to increase the access to care for all children and to allow providers reimbursement for those separate screens. When expanded HCY services are accessed through a partial or interperiodic screen, it is the responsibility of the provider completing the partial or interperiodic screening service to have a referral source to send the child for the remaining components of a full screening service.

Office visits and screenings that occur on the same day by the same provider are *not* covered unless the medical necessity is clearly documented in the participant's record.

9.6.A DEVELOPMENTAL ASSESSMENT

PROCEDURE CODE	DESCRIPTION
99429 59	Developmental/Mental/Behavioral Health partial screen
99429 59UC	Developmental/Mental/Behavioral Health partial screen with Referral

Periodic developmental and behavioral screening during early childhood is essential to identify possible delays in growth and development, when steps to address deficits can be most effective. The MHD encourages providers to use age appropriate, validated screening tools rather than less rigorous methods to screen for developmental and mental/behavioral health conditions. The Screening Technical Assistance & Resource (STAR) Center of the AAP provides a list of validated screening tools for children 0 to 5 years that address the following areas:

- Development
- Autism
- Social-emotional development
- Maternal depression
- Social determinants of health

The STAR Center list may be accessed at https://screeningtime.org/star-center/#/screening-tools#top.

Maternal depression is a serious and widespread condition that not only affects the mother, but may have a lasting, detrimental impact on the child's health. As a reminder, MHD covers procedure code 96161, which may be billed under the child's DCN, for administering a maternal depression screening tool during a well-child visit.

9.6.A(1) Qualified Providers

The Developmental/Mental Health partial screen may be provided by the following MO HealthNet enrolled providers:

- Physician, nurse practitioner, assistant physician, physician assistant or nurse midwife*;

- Speech/language therapist;
- Physical therapist
- Occupational therapist; or
- Professional counselors, social workers, marital and family therapists, and psychologists.

*only infants age 0-2 months; and females age 15-20 years

9.6.B UNCLOTHED PHYSICAL, ANTICIPATORY GUIDANCE, AND INTERVAL HISTORY, LAB/IMMUNIZATIONS AND LEAD SCREEN

PROCEDURE CODE	DESCRIPTION
9938152EP-9938552EP 9939152EP-9939552EP	HCY Unclothed Physical and History
9938152EPUC-9938552EPUC 9939152EPUC-9939552EPUC	HCY Unclothed Physical and History with Referral

The HCY unclothed physical and history includes the following:

- Check of growth chart;
- Examination of skin, head (including otoscopy and ophthalmoscopy), neck, external genitals, extremities, chest, hips, heart, abdomen, feet, and cover test;
- Appropriate laboratory;
- Immunizations; and
- Lead screening according to established guidelines.

9.6.B(1) Qualified Providers

The screen may be provided by a MO HealthNet enrolled physician, nurse practitioner, assistant physician, physician assistant or nurse midwife*.

*Reimbursement for immunizations and laboratory procedures is *not* included in the screening fee and may be billed separately.

9.6.C VISION SCREENING

PROCEDURE CODE	DESCRIPTION

9942952	Vision Screening
9942952UC	Vision Screening with Referral

This screen can include observations for blinking, tracking, corneal light reflex, pupillary response, ocular movements. To test for visual acuity, use the Cover test for children under 3 years of age. For children over 3 years of age utilize the Snellen Vision Chart.

9.6.C(1) Qualified Providers

The vision partial screen may be provided by the following MO HealthNet enrolled providers:

- Physician, nurse practitioner, assistant physician, physician assistant or nurse midwife*;
- Optometrist.

* only infants age 0-2 months; and females age 15-20 years

9.6.D HEARING SCREEN

PROCEDURE CODE	DESCRIPTION
99429EP	HCY Hearing Screen
99429EPUC	HCY Hearing Screen with Referral

This screen can range from reports by parents to assessment of the child's speech development through the use of audiometry and tympanometry.

If performed, audiometry and tympanometry tests may be billed and reimbursed separately. These tests are *not* required to complete the hearing screen.

9.6.D(1) Qualified Providers

The hearing partial screen may be provided by the following MO HealthNet enrolled providers:

- Physician, nurse practitioner, assistant physician, physician assistant or nurse midwife*;
- Audiologist or hearing aid dealer/fitter; or

- Speech pathologist.

*Reimbursement for immunizations and laboratory procedures is *not* included in the screening fee and may be billed separately.

9.6.E DENTAL SCREEN

PROCEDURE CODE	DESCRIPTION
99429	HCY Dental Screen
99429UC	HCY Dental Screen with Referral

A dental screen is available to the HCY/EPSDT population on a periodicity schedule that is different from that of the full HCY/EPSDT screen.

Children may receive age-appropriate dental screens and treatment services until they become 21 years old. *A child's first visit to the dentist should occur no later than 12 months of age so that the dentist can evaluate the infant's oral health, intercept potential problems such as nursing caries, and educate parents in the prevention of dental disease in their child.* It is recommended that preventive dental services and oral treatment for children begin at age 6 to 12 months and be repeated every six months or as indicated.

When a child receives a full medical screen by a physician, nurse practitioner or nurse midwife*, it includes an oral examination, which is *not* a full dental screen. A referral to a dental provider *must* be made where medically indicated when the child is under the age of 1 year. When the child is 1 year or older, a referral *must* be made, at a minimum, according to the dental periodicity schedule. The physician, nurse practitioner or nurse midwife may *not* bill the dental screening procedure 99429 or 99429UC separately.

*only infants age 0-2 months; and females age 15-20 years

9.6.E(1) Qualified Providers

A dental partial screen may only be provided by a MO HealthNet participating dentist.

9.6. F ALL PARTIAL SCREENERS

The provider of a partial medical screen *must* have a referral source to send the participant for the remaining required components of the full medical screen and is expected to help make arrangements for this service.

9.7 LEAD RISK ASSESSMENT AND TREATMENT—HEALTHY CHILDREN AND YOUTH (HCY)

The Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) has identified all children between 6 months and 72 months to be at risk for lead poisoning and has mandated they *must* receive a lead risk assessment as part of the HCY full or partial screening.

A complete lead risk assessment consists of a verbal risk assessment and blood test(s) when indicated, and at the mandatory testing ages of 12 and 24 months. Lead risk assessment is included as a component of a full HCY medical screen, 99381EP through 99385EP and 99391EP through 99395EP, or a partial HCY screen, 9938152EP through 9938552EP and 9939152EP through 9939552EP, which also includes the following components: Interval History, Unclothed Physical, Anticipatory Guidance, Lab, and Immunization. See Section 9.7.B for additional information.

CMS has also determined that there are no guidelines or policies for states or local health departments to reference in determining that an area is a lead free zone. Until there is specific information or guidance from the Centers for Disease Control (CDC) on how lead free zones are determined, CMS will *not* recognize them in the context of screening Medicaid eligible children for lead poisoning.

9.7.A SIGNS, SYMPTOMS AND EXPOSURE PATHWAYS

The signs and symptoms of lead exposure and toxicity may vary because of differences in individual susceptibility. A continuum of signs and symptoms exist, ranging from asymptomatic persons to those with overt toxicity.

Mild toxicity is usually associated with blood lead levels in the 35 to 50 µg/dL range for children and in the 40 to 60 µg/dL range for adults. Severe toxicity is frequently found in association with blood lead levels of 70 µg/dL or more in children and 100 µg/dL or more in adults.

The following signs and symptoms and exposure pathways are provided to assist providers in identifying children who may have lead poisoning or be at risk of being poisoned.

SIGNS AND SYMPTOMS

MILD TOXICITY	**SEVERE TOXICITY**
Myalgia or paresthesia	Paresis or paralysis

Mild fatigue
Irritability
Lethargy
Occasional abdominal discomfort

Encephalopathy—may abruptly lead to seizures, changes in level of consciousness, coma and death
Lead line (blue-black) on gingival tissue
Colic (intermittent, severe abdominal cramps)

MODERATE TOXICITY

Arthralgia
General fatigue
Decrease in play activity
Difficulty concentrating
Muscular exhaustibility
Tremor
Headache
Diffuse abdominal pain
Vomiting
Weight loss
Constipation

EXPOSURE PATHWAYS

OCCUPATIONAL

Plumbers, pipe fitters
Lead miners
Lead smelters and refiners
Auto repairers
Glass manufacturers
Shipbuilders
Printers
Plastic manufacturers
Police Officers
Steel welders and cutters
Construction workers
Bridge reconstruction workers
Rubber products manufacturers
Gas station attendants
Battery manufacturers
Chemical and chemical preparation
Manufacturers
Industrial machinery and equipment operators
Firing Range Instructors
ENVIRONMENTAL
Lead-containing paint
Soil/dust near industries, roadways, lead-painted homes
painted homes
Plumbing leachate
Ceramic ware
Leaded gasoline

HOBBIES AND RELATED ACTIVITIES

Glazed pottery making
Target shooting at firing ranges
Lead soldering (e.g., electronics)
Painting
Preparing lead shot, fishing sinkers, bullets
Home remodeling
Stained-glass making
Car or boat repair

SUBSTANCE USE

Folk remedies
“Health foods”
Cosmetics
Moonshine whiskey
Gasoline “huffing”

Regardless of risk, all families *must* be given detailed lead poisoning prevention counseling as part of the anticipatory guidance during the HCY screening visit for children up to 72 months of age.

9.7.B LEAD RISK ASSESSMENT

The HCY Lead Risk Assessment Guide should be used at *each* HCY screening to assess the exposure to lead, and to determine the risk for high dose exposure. The HCY Lead Risk Assessment Guide is designed to allow the same document to follow the child for all visits from 6 months to 6 years of age. The HCY Lead Risk Assessment Guide has space on the reverse side to identify the type of blood test, venous or capillary, and also has space to identify the dates and results of blood lead levels.

A comprehensive lead risk assessment includes both the verbal lead risk assessment and blood lead level determinations. Blood Lead Testing is mandatory at 12 and 24 months of age and if the child is deemed high risk.

The HCY Lead Risk Assessment Guide is available for provider's use. The tool contains a list of questions that require a response from the parent. A positive response to any of the questions requires blood lead level testing by capillary or venous method.

9.7.C MANDATORY RISK ASSESSMENT FOR LEAD POISONING

All children between the ages of 6 months and 72 months of age MUST receive a lead risk assessment as a part of the HCY full or partial screening. Providers are *not* required to wait until the next HCY screening interval and may complete the lead risk assessment at the next office visit if they choose.

The HCY Lead Risk Assessment Guide and results of the blood lead test *must* be in the patient's medical record even if the blood lead test was performed by someone other than the billing provider. If this information is *not* located in the medical record a full or partial HCY screen may *not* be billed.

9.7.C(1) Risk Assessment

Beginning at six months of age and at each visit thereafter up to 72 months of age, the provider *must* discuss with the child's parent or guardian childhood lead poisoning interventions and assess the child's risk for exposure by using the HCY Lead Risk Assessment Guide.

9.7.C(2) Determining Risk

Risk is determined from the response to the questions on the HCY Lead Risk Assessment Guide. This verbal risk assessment determines the child to be low risk or high risk.

- If the answers to all questions is no, a child is *not* considered at risk for high doses of lead exposure.
- If the answer to any question is yes, a child is considered *at risk* for high doses of lead exposure and a capillary or venous blood lead level *must* be drawn. Follow-up guidelines on the reverse side of the HCY Lead Risk Assessment Guide *must* be followed as noted depending on the blood test results.

Subsequent verbal lead risk assessments can change a child's risk category. As the result of a verbal lead risk assessment, a previously low risk child may be re-categorized as high risk.

9.7.C(3) Screening Blood Tests

The Centers for Medicare & Medicaid Services (CMS) requires mandatory blood lead testing by either capillary or venous method at 12 months and 24 months of age regardless of risk. If the answer to any question on the HCY Lead Risk Assessment Guide is positive, a venous or capillary blood test *must* be performed.

If a child is determined by the verbal risk assessment to be high risk, a blood lead level test is required, beginning at six months of age. If the initial blood lead level test results are less than 10 micrograms per deciliter (µg/dL) no further action is required. Subsequent verbal lead risk assessments can change a child's risk category. A verbal risk assessment is required at every visit prescribed in the EPSDT periodicity schedule through 72 months of age and if considered to be high risk *must* receive a blood lead level test, unless the child has already received a blood lead test within the last six months of the periodic visit.

A blood lead test result equal to or greater than 10 µg/dL obtained by capillary specimen (finger stick) *must* be confirmed using venous blood according to the time frame listed below:

- 10-19 µg/dL- confirm within 2 months
- 20-44 µg/dL- confirm within 2 weeks
- 45-69 µg/dL- confirm within 2 days
- 70+ µg/dL- IMMEDIATELY

For future reference and follow-up care, completion of the HCY Lead Risk Assessment Guide is still required at these visits to determine if a child is at risk.

9.7.C(4) MO HealthNet Managed Care Health Plans

The MO HealthNet Managed Care health plans are responsible for mandatory risk assessment for children between the ages of 6 months and 72 months. MO HealthNet Managed Care health plans are also responsible for mandatory blood testing if a child is at risk or if the child is 12 or 24 months of age. MO HealthNet Managed Care health plans *must* follow the HCY Lead Risk Assessment Guide when assessing a child for risk of lead poisoning or when treating a child found to be poisoned.

MO HealthNet Managed Care health plans are responsible for lead case management for those children with elevated blood lead levels. MO HealthNet Managed Care health plans are encouraged to work closely with the MO HealthNet Division and local public health agencies when a child with an elevated blood lead level has been identified.

Referral for an environmental investigation of the child's residence *must* be made to the local public health agency. This investigation is *not* the responsibility of the MO HealthNet Managed Care health plan, but can be reimbursed by the MO HealthNet Division on a fee-for-service basis.

9.7.D LABORATORY REQUIREMENTS FOR BLOOD LEAD LEVEL TESTING

When performing a lead risk assessment in Medicaid eligible children, CMS requires the use of the blood lead level test at 12 and 24 months of age and when a child is deemed high risk. The erythrocyte protoporphyrin (EP) test is *not* acceptable as a blood lead level test for lead poisoning. The following procedure code *must* be used to bill the blood lead test:

(Capillary specimen or venous blood samples.)

PROCEDURE CODE	DESCRIPTION
83655	Lead, quantitative blood

This code *must* be used by MO HealthNet enrolled laboratories. Laboratories *must* be CLIA certified to perform blood lead level tests. All blood lead level tests *must* be reported to the Missouri Department of Health and Senior Services as required in 19 CSR 20-20.

9.7.E BLOOD LEAD LEVEL—RECOMMENDED INTERVENTIONS

9.7.E(1) Blood Lead Level <10 µg/dL

This level is *NOT* indicative of lead poisoning. No action required unless exposure sources change.

Recommended Interventions:

- The provider should refer to Section 9.8.C(3) and follow the guidelines for risk assessment blood tests.

9.7.E(2) Blood Lead Level 10-19 µg/dL

Children with results in this range are in the borderline category. The effects of lead at this level are subtle and are *not* likely to be measurable or recognizable in the individual child.

Recommended Interventions:

- Provide family education and follow-up testing.
- *Retest every 2-3 months.
- If 2 venous tests taken at least 3 months apart both result in elevations of 15 µg/dL or greater, proceed with retest intervals and follow-up guidelines as for blood lead levels of 20-44 µg/dL.

*Retesting *must* always be completed using venous blood.

9.7.E(3) Blood Lead Level 20-44 µg/dL

If the blood lead results are in the 20-44 µg/dL range, a confirmatory venous blood lead level *must* be obtained within 2 weeks. Based upon the confirmation, a complete medical evaluation *must* be conducted.

Recommended Interventions:

- Provide family education and follow-up testing.
- Assure coordination of care (case management) either through the MO HealthNet Managed Care health plan, provider or local public health agency. The provider assures medical management.
- Contact local public health agency to provide environmental investigation and to assure lead-hazard control.
- *Retest every 1-2 months until the blood lead level remains less than 15 µg/dL for at least 6 months, lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19 µg/dL.

*Retesting *must* always be completed using venous blood.

9.7.E(4) Blood Lead Level 45-69 µg/dL

These children require urgent medical evaluation.

If the blood lead results are in the 45-69 µg/dL range, a confirmatory venous blood lead level *must* be obtained within 48 hours.

Children with symptomatic lead poisoning (with or without encephalopathy) *must* be referred to a setting that encompasses the management of acute medical emergencies.

Recommended Interventions:

- Provide family education and follow-up testing.
- Assure coordination of care (case management) either through the MO HealthNet Managed Care health plan, provider or local public health agency. The provider assures medical management.
- Contact local public health agency to provide environmental investigation and to assure lead-hazard control.
- Within 48 hours begin coordination of care (case management), medical management, environmental investigation, and lead hazard control.
- A child with a confirmed blood lead level greater than 44 µg/dL should be treated promptly with appropriate chelating agents and *not* returned to an environment where lead hazard exposure may continue until it is controlled.
- *Retest every 1-2 months until the blood lead level remains less than 15 µg/dL for at least 6 months, lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19 µg/dL.

* Retesting *must* always be completed using venous blood.

9.7.E(5) Blood Lead Level 70 µg/dL or Greater

Children with blood lead levels in this range constitute a medical emergency.

If the blood lead results are in the 70 µg/dL range, a confirmatory venous blood lead level *must* be obtained immediately.

Recommended Interventions:

- Hospitalize child and begin medical treatment immediately.

- Begin coordination of care (case management), medical management, environmental investigation, and lead hazard control immediately.
- Blood lead levels greater than 69 µg/dL *must* have an urgent repeat venous test, but chelation therapy should begin immediately (*not* delayed until test results are available.)
- *Retest every 1-2 months until the blood lead level remains less than 15 µg/dL for at least 6 months, the lead hazards have been removed, and there are no new exposures.
- When these conditions are met, proceed with guidelines for blood lead levels 10-19 µg/dL.

* Retesting *must* always be completed using venous blood.

9.7.F COORDINATION WITH OTHER AGENCIES

Coordination with local health departments, WIC, Head Start, and other private and public resources enables elimination of duplicate testing and ensures comprehensive diagnosis and treatment. Also, local public health agencies' Childhood Lead Poisoning Prevention programs may be available. These agencies may have the authority and ability to investigate a lead-poisoned child's environment and to require remediation. Local public health agencies may have the authority and ability to investigate a lead poisoned child's environment. We encourage providers to note referrals and coordination with other agencies in the patient's medical record.

9.7.G ENVIRONMENTAL LEAD INVESTIGATION

When two consecutive lab tests performed at least three months apart measure 15 µg/dL or above, an environmental investigation *must be obtained.* Furthermore, where there is a reading above 10 µg/dL, the child *must* be re-tested in accordance to the recommended interventions listed in Section 9.8.E.

9.7.G(1) Environmental Lead Investigation

Children who have a blood lead level 20 µg/dL or greater or children who have had 2 blood lead levels greater than 15 µg/dL at least 3 months apart should have an environmental investigation performed.

The purpose of the environmental lead investigation is to determine the source(s) of hazardous lead exposure in the residential environment of children with elevated blood lead levels. Environmental lead investigations are to be conducted by licensed lead risk assessors who have been approved by the Missouri Department of Health and Senior Services. Approved licensed lead risk assessors shall comply

with the Missouri Department of Health and Senior Services Lead Manual and applicable State laws.

All licensed lead risk assessors *must* be registered with the Missouri Department of Health and Senior Services. Approved lead risk assessors who wish to receive reimbursement for MO HealthNet eligible children *must* also be enrolled as a MO HealthNet provider. Lead risk assessors *must* use their MO HealthNet provider number when submitting claims for completing an environmental lead investigation.

The following procedure codes have been established for billing environmental lead investigations:

T1029UATG	Initial Environmental Lead Investigation
T1029UA	First Environmental Lead Reinvestigation
T1029UATF	Second Environmental Lead Reinvestigation
T1029UATS	Subsequent Environmental Lead Reinvestigation Certificate of Medical Necessity *must* be attached to claim for this procedure

Federal Medicaid regulations prohibit Medicaid coverage of environmental lead investigations of locations other than the principle residence. The Missouri Department of Health and Senior Services recommend that all sites where the child may be exposed be assessed, e.g., day care, grandparents' home, etc.

Federal Health Care Financing policy prohibits Medicaid paying for laboratory testing of paint, soil and water samples.

Contact the local health department to arrange for environmental lead investigation services.

9.7.H ABATEMENT

Medicaid *cannot* pay for abatement of lead hazards. Lead risk assessors may be able to provide information and advice on proper abatement and remediation techniques.

9.7.I LEAD CASE MANAGEMENT

Children with 1 blood lead level of 20 µg/dL or greater, or who have had 2 venous tests at least 3 months apart with elevations of 15 µg/dL or greater *must* be referred for case management services through the HCY Program. In order to be reimbursed for these services the lead case management agency *must* be an enrolled provider with MO HealthNet Division.

For additional information on Lead Case Management, go to Section 13.66.D of the Physician's Program Provider Manual.

9.7.J POISON CONTROL HOTLINE TELEPHONE NUMBER

The statewide poison control hotline number is (800) 366-8888. This number may also be used to report suspected lead poisoning. The Department of Health and Senior Services, Section for Environmental Health, hotline number is (800) 392-0272.

9.7.K MO HEALTHNET ENROLLED LABORATORIES THAT PERFORM BLOOD LEAD TESTING

Children's Mercy Hospital
2401 Gillham Rd.
Kansas City, MO 64108

Hannibal Clinic Lab

711 Grand Avenue

Hannibal, MO 63401

Kansas City Health Department Lab
2400 Troost, LL#100
Kansas City, MO 64108

Missouri State Public Health Laboratory
101 Chestnut St,
Jefferson City, MO 65101

Springfield-Greene County Public Health
227 E. Chestnut
Springfield, MO 65802

St. Luke's Hospital Dept. of Pathology
4401 Wornall
Kansas City, MO

University of MO-Columbia Hospital & Clinics
One Hospital Drive
Columbia, MO 65212

Kneibert Clinic, LLC PO Box

PO Box 220

Poplar Bluff, MO 63902

LabCorp Holdings-Kansas City
1706 N. Corrington
Kansas City, MO 64120

Physicians Reference Laboratory
7800 W. 110 St.
Overland, MO 66210

Quest Diagnostics
11636 Administration
St. Louis, MO 63146

St. Francis Medical Center
211 St. Francis Drive
Cape Girardeau, MO 63703

St. Louis County Environmental Health Lab
111 S. Meramec
Clayton, MO 63105

9.7.L OUT-OF-STATE LABS CURRENTLY REPORTING LEAD TEST RESULTS TO THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

Arup Laboratories

500 Chipeta Way

Esa

22 Alpha Rd.

Salt Lake City, UT 84108

Iowa Hygenic Lab

Wallace State Office Building

Des Moines, IA 50307

Kansas Department of Health

619 Anne Ave.

Kansas City, KS 66101

Leadcare, Inc.

52 Court Ave.

Stewart Manor, NY 11530

Quincy Medical Group

1025 Main St.

Quincy, IL 62301

Chelmsford, MA 01824

Iowa Methodist Medical Center
1200 Pleasant St.
Des Moines, IA 50309

Mayo Medical Laboratories

2050 Superior Dr. NW

Rochester, MN 55901

Physician's Reference Laboratory
7800 W. 110th St.
Overland Park, KS 66210

Tamarac Medical

7800 Broadway Ste. 2C

Centennial, Co 80122

Specialty Laboratories
2211 Michigan Ave.
Santa Monica, CA 90404

9.8 HCY CASE MANAGEMENT

PROCEDURE CODE	DESCRIPTION
T1016EP	HCY Case Management
T1016TSEP	HCY Case Management; Follow-up

For more information regarding HCY Case Management, refer to Section 13 of the Physician's Program Provider Manual.

9.9 IMMUNIZATIONS

Immunizations *must* be provided during a full medical HCY screening unless medically contraindicated or refused by the parent or guardian of the patient. When an appropriate immunization is *not* provided, the patient's medical record *must* document why the appropriate immunization was *not* provided. Immunization against polio, measles, mumps, rubella, pertussis, chicken pox, diphtheria, tetanus, haemophilus influenzae type b, and hepatitis B *must* be provided according to the Recommended Childhood Immunization Schedule found on the Department of Health and Senior Services' website at: http://www.dhss.mo.gov/Immunizations/index.html.

9.9.A VACCINE FOR CHILDREN (VFC)

For information on the Vaccine for Children (VFC) program, reference Section 13 of the Physician's Program Provider Manual.

9.10 ASSIGNMENT OF SCREENING TIMES

Participants under 21 years of age become eligible for the initial screening, as well as for the periodic screenings, at the time MO HealthNet eligibility is determined regardless of how old they are. A periodic screen should occur thereafter according to the established periodicity schedule. A notification letter is sent in the month the participant again becomes eligible for an HCY screening. The letter is to notify the participant that a screening is due.

9.11 PERIODICITY SCHEDULE FOR HCY (EPSDT) SCREENING SERVICES

The periodicity schedule represents the minimum requirements for frequency of full medical screening services. Its purpose is *not* to limit the availability of needed treatment services between the established intervals of the periodicity schedule.

The MO HealthNet Division follows the Bright Futures Periodicity schedule as a standard for pediatric preventive services. Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) and supported by the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA).

Note: MO HealthNet recognizes that a full HCY screen is required for children/youth within 30 days of entering Children's Division custody. Also, the American Academy of Pediatrics recommends additional monitoring for children and adolescents in foster care (see https://pediatrics.aappublications.org/content/pediatrics/136/4/e1131.full.pdf and https://pediatrics.aappublications.org/content/136/4/e1142). Such HCY screens are considered medically necessary even though they may occur in addition to the standard periodicity schedule.

Children may be screened at any time the physician, nurse practitioner or nurse midwife* feels it is medically necessary to provide additional screening services. *If it is medically necessary for a full medical screen* (s*ee Section 9.6 for procedure list) to occur more frequently than the suggested periodicity schedule, then the screen should be provided. There must, however, be documentation in the patient's medical record that indicates the medical necessity of the additional full medical screening service.*

The HCY Program makes available to MO HealthNet participants under the age of 21 a full HCY screening examination during each of the age categories in the following periodicity schedule:

Newborn	3 Years
3-4 Days	4 Years
By 1 Month	5 Years
2 Months	6 Years
4 Months	7 Years
6 Months	8 Years
9 Months	9 Years
12 Months	10 Years
15 Months	11 Years
18 Months	12 Years
24 Months	13 Years
30 Months	14 Years
	15 Years
	16 Years
	17 Years
	18 Years
	19 Years
	20 Years

*only infants age 0-2 months; and females age 15-20 years

9.11.A DENTAL SCREENING SCHEDULE

- Twice a year from age 6 months to 21 years.

9.11.B VISION SCREENING SCHEDULE

- Once a year from age 3 to 21 years.

9.11.C HEARING SCREENING SCHEDULE

- Once a year from age 3 to 21 years.

9.12 REFERRALS RESULTING FROM A FULL, INTERPERIODIC OR PARTIAL SCREENING

The full HCY screen is to serve as a complete screen and should *not* result in a referral for an additional partial screen for the component that identified a need for further assessment or treatment. A child referred as a result of a full screen should be referred for diagnostic or treatment services and *not* for additional screening except for dental (see Section 9.7.E).

Diagnostic and treatment services beyond the scope of the Medicaid state plan may require a plan of care and prior authorization (see Section 9.13.A). Additional information regarding specialized services can be found in Section 13, Benefits and Limitations.

9.12.A PRIOR AUTHORIZATION FOR NON-STATE PLAN SERVICES (EXPANDED HCY SERVICES)

Medically necessary services beyond the scope of the traditional Medicaid Program may be provided when the need for these services is identified by a complete, interperiodic or partial HCY screening. When required, prior authorization *must* be requested prior to delivering services. Refer to instructions found in Section 13 of the provider manual for information on services requiring prior authorization. Complete the Prior Authorization Request form in full, describing in full detail the service being requested and submit in accordance with requirements in Section 13 of the provider manual.

Section 8 of the provider manual indicates exceptions to the prior authorization requirement and gives further details regarding completion of the form. Section 14 may also include specific requirements regarding the prior authorization requirement.

9.13 PARTICIPANT NONLIABILITY

MO HealthNet covered services rendered to an eligible participant are *not* billable to the participant if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

9.14 EXEMPTION FROM COST SHARING AND COPAY REQUIREMENTS

The MO HealthNet Division (MHD) does not require participant cost sharing or copays for any services at this time. Providers will be notified when participant cost sharing and copay requirements are reinstated.

9.15 STATE-ONLY FUNDED PARTICIPANTS

Children eligible under a state-only funded category of assistance are eligible for all services including those available through the HCY Program to the same degree any other person under the age of 21 years is eligible for a service. Refer to Section 1 for further information regarding state-only funded participants.

9.16 MO HEALTHNET MANAGED CARE

MO HealthNet Managed Care health plans are responsible for ensuring that Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) screens are performed on all MO HealthNet Managed Care eligibles under the age of 21.

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid provide medically necessary services to children from birth through age 20 years which are necessary to treat or improve defects, physical or mental illness, or conditions identified by an EPSDT screen regardless of whether or not the services are covered under the Medicaid state plan. Services *must* be sufficient in amount, duration and scope to reasonably achieve their purpose and may only be limited by medical necessity. According to the MO HealthNet Managed Care contracts, the MO HealthNet Managed Care health plans are responsible for providing all EPSDT/HCY services for their enrollees.

Missouri is required to provide the Centers for Medicare & Medicaid Services with screening and referral data each federal fiscal year (FFY). This information is reported to CMS on the CMS-416 report. Specific guidelines and requirements are required when completing this report. The health plans are *not* required to produce a CMS-416 report. Plans *must* report encounter data for HCY screens using the appropriate codes in order for the MO HealthNet Division to complete the CMS-416 report.

A full EPSDT/HCY screening *must* include the following components:

a) A comprehensive unclothed physical examination

b) A comprehensive health and developmental history including assessment of both physical and mental/behavioral health development

c) Health education (including anticipatory guidance)

d) Appropriate immunizations according to age

e) Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated)

f) Lead screen according to established guidelines

g) Hearing screen

h) Vision screen

i) Dental screen

Partial screens which are segments of the full screen may be provided by appropriate providers. The purpose of this is to increase access to care to all children. Providers of partial screens are required to supply a referral source for the full screen. (For the plan enrollees this should be the primary care physician). A partial screen does *not* replace the need for a full medical screen which includes all of the above components. See Section 9, page 5 through 8 for specific information on partial screens.

Plans *must* use the following procedure codes, along with a primary diagnosis code of Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, or Z00.129 when reporting encounter data to the MO HealthNet Division on Full and Partial EPSDT/HCY Screens:

Full Screen	99381EP through 99385EP and 99391EP through 99395EP
Unclothed Physical and History	99381 through 99385 and 99391 through 99395
Developmental/Mental Health	9942959 9942959UC
Hearing Screen	99429EP 99429EPUC
Vision Screen	9942952 9942952UC
Dental Screen	99429 99429UC

The history and exam of a normal newborn infant and initiation of diagnostic and treatment programs may be reported by the plans with procedure code 99460. Normal newborn care in other than a hospital or birthing room setting may be reported by the plans with procedure code 99461. Both of the above newborn procedure codes are equivalent to a full HCY screening.

Plans are responsible for required immunizations and recommended laboratory tests. Lab services are *not* part of the screen and are reported separately using the appropriate CPT code. Immunizations are recommended in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines and acceptable medical practice.

If a problem is detected during a screening examination, the child *must* be evaluated as necessary for further diagnosis and treatment services. The MO HealthNet Managed Care health plan is responsible for the treatment services.

9.17 ORDERING HCY LEAD SCREENING GUIDE

The HCY Lead Screening Guide may be ordered from Wipro Infocrossing Healthcare Services, P.O. Box 5600, Jefferson City, Missouri 65102 by checking the appropriate item on the Forms Request. If a provider needs additional screening forms they can also make copies.

END OF SECTION

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SECTION 10 - FAMILY PLANNING

Family planning services are services relating to elective sterilizations and birth control products including drugs, diaphragms, and IUDs.

Section 10, The Family Planning Section, is *not* applicable to the following manuals:

Adult Day Care Waiver
Adult Day Health Care (NOTE: The Adult Day Health Care Program ends June 30, 2013)
Aged and Disabled Waiver
AIDS Waiver
Ambulance
Comprehensive Day Rehabilitation
Dental
Durable Medical Equipment
Environmental Lead Assessment
Hearing Aid
Hospice
Independent Living Waiver
Medically Fragile Adult Waiver
Nursing Home
Optical
Personal Care
Private Duty Nursing
Psychology/Counseling
Rehabilitation Centers
Therapy

END OF SECTION

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SECTION 11 - MO HEALTHNET MANAGED CARE PROGRAM DELIVERY SYSTEM

MO HealthNet provides health care services to Managed Care eligibles who meet the criteria for enrollment through Managed Care arrangements, as follows:

- Under MO HealthNet's Managed Care Program certain eligible individuals are enrolled with a MO HealthNet Managed Care Health Plan. Managed Care has been implemented statewide, operating in four (4) regions of the state: Eastern (St. Louis area), Central, Southwestern, and Western (Kansas City area)regions.

11.1 MO HEALTHNET'S MANAGED CARE PROGRAM

Managed Care eligibles who meet specific eligibility criteria receive services through a Managed Care Health Plan. The Managed Care Program replaces the process of direct reimbursement to individual providers by the MO HealthNet Division (MHD). Participants enroll in a Managed Care Health Plan that contracts with the state to provide a specific scope of benefits. Individuals who are included in the Managed Care Program have the opportunity to choose their own Managed Care Health Plan and primary care provider. A listing of the health plans providing services statewide for the Managed Care Program can be found on the MHD website at: http://dss.mo.gov/mhd/participants/mc/managed-care-health-plan-options.htm.

11.1.A EASTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The Eastern Missouri Managed Care Program (St. Louis area) began providing services to members on September 1, 1995. It includes the following counties: Franklin (036), Jefferson (050), St. Charles (092), St. Louis County (096) and St. Louis City (115). On December 1, 2000, five new counties were added to this region: Lincoln (057), St. Genevieve (095), St. Francois (094), Warren (109) and Washington (110). On January 1, 2008, the following three new counties were added to the Eastern region: Madison (062), Perry (079) and Pike (082).

11.1.B CENTRAL MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The central Missouri Managed Care region began providing services to members on March 1, 1996. It includes the following counties: Audrain (004), Boone (010), Callaway (014), Camden (015), Chariton (021), Cole (026), Cooper (027), Gasconade (037), Howard (045), Miller (066), Moniteau (068), Monroe (069), Montgomery (070), Morgan (071), Osage (076), Pettis (080), Randolph (088) and Saline (097). On January 1, 2008, ten new counties were added to this region: Benton (008), Laclede (053), Linn (058), Macon (061), Maries (063), Marion (064), Phelps (081), Pulaski (085), Ralls (087) and Shelby (102). On May 1, 2017, forty new counties were added to this region: Adair (001), Andrew (002), Atchison (003), Bollinger (009), Buchanan (011), Butler (012), Caldwell (013), Cape Girardeau (016), Carroll (017), Carter (018), Clark (023), Clinton (025), Crawford (028), Davies (031), DeKalb (032), Dent (033),

Dunklin (035), Gentry (038), Grundy (040), Harrison (041), Holt (044), Iron (047), Knox (052), Lewis (056), Livingston (059), Mercer (065), Mississippi (067), New Madrid (072), Nodaway (074), Pemiscot (078), Putnam (86), Reynolds (090), Ripley (091), Schuyler (098), Scotland (099), Scott (100), Stoddard (103), Sullivan (105), Wayne (111), and Worth (113).

11.1.D SOUTHWESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The Southwestern Missouri Managed Care Program began providing services to members on May 1, 2017. The southwestern Managed Care region includes the following counties: Barry (005), Barton (006), Christian (02), Dade (029), Dallas (030), Douglas (034), Greene (039), Hickory (043), Howell (046), Jasper (019), Lawrence (055), McDonald (060), Newton (073), Oregon (075), Ozark (077), Shannon (101), Stone (104), Taney (106), Texas (107), Webster (112), and Wright (114).

11.1.E WESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The Western Missouri Managed Care Program (Kansas City area) began providing services to members on November 1, 1996. The western Managed Care region includes the following counties: Cass (019), Clay (024), Jackson (048), Johnson (051), Lafayette (054), Platte (083) and Ray (089). St. Clair (093) and Henry (042) counties were incorporated into the Western region effective 2/1/99. On January 1, 2008 four new counties were added to this region: Bates (007), Cedar (020), Polk (084) and Vernon (108).

11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT

The state has contracted with an independent enrollment agent to assist current and future MO HealthNet Managed Care participants to make an informed decision in the choice of a MO HealthNet Managed Care Health Plan that meets their needs.

The Managed Care enrollment agent sends mailers/letters, etc., provides MO HealthNet Managed Care Health Plan option information, and has a hot line number available to participants in order to make the selection process easy and informative.

Pregnant women who are identified as eligible for inclusion in the MO HealthNet Managed Care Program have 7 days to select a Managed Care health plan or have a Managed Care health plan assigned for them. After they have selected the Managed Care health plan, they are not enrolled with a MO HealthNet Managed Care health plan until 7 days after they actually select or are assigned to a Managed Care health plan. All other participants who are identified as eligible for inclusion in the MO HealthNet Managed Care Program have 15 days to select a Managed Care health plan or have a Managed Care health plan assigned for them. After they have selected the Managed Care health plan, participants are *not* enrolled with a MO HealthNet Managed Care health plan until 15 days after they actually select or are assigned to a Managed Care health plan. When the selection or assignment is in effect, the name of the MO HealthNet Managed Care health plan appears on the Interactive Voice Response system/eMOMED information. If a MO HealthNet Managed Care health plan name does *not* appear for a particular date of service, the participant is in a Fee-For-Service eligibility status. The participant is in

a Fee-For-Service eligibility status for each date of service that a MO HealthNet Managed Care health plan is *not* listed for the participant.

"OPT OUT" POPULATIONS: The Department of Social Services allows participants the option of choosing to receive services on a Fee-For-Service basis or through the MO HealthNet Managed Care Program. Participants are eligible to opt out if they are in the following classifications:

- Eligible for Supplemental Security Income (SSI) under Title XVI of the Act;
- Described in Section 501(a)(1)(D) of the Act (children with special health care needs); or
- Described in Section 1902 €(3) of the Act (18 or younger and qualifies as a disabled individual under section 1614(a)).

Fee-For-Service Members or their parent/guardian should call Participant Services at 1-800-392-2161. Participant Services will provide a form to request "Opt Out". Once all information is received, a determination is made.

11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS

Refer to Section 1.5.C, MO HealthNet Managed Care Participants, and 1.1.A, Description of Eligibility Categories, for more information on Managed Care Health Plan members.

Managed Care Health Plan members fall into four groups:

- Individuals with the following ME Codes fall into Group 1: 05, 06, 10, 19, 21, 24, 26, 40, 60, and 62.
- Individuals with the following ME Codes fall into Group 2: 18, 43, 44, 45, 61, 95, 96, and 98.
- Individuals with the following ME Codes fall into Group 4: 07, 08, 29, 30, 36, 37, 38, 50, 52, 56, 57, 64, 66, 68, 69 and 70.
- Individuals with the following ME Codes fall into Group 5: 71, 72, 73, 74, 75 and 97.

11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS

The following categories of assistance/individuals are *not* included in the MO HealthNet Managed Care Program.

- Permanently and Totally Disabled and Aged individuals eligible under ME Codes 04 (Permanently and Totally Disabled), 13 (MO HealthNet-PTD), 16 (Nursing Care-PTD), 11 (MO HealthNet Spend down and Non-Spend down), 14 (Nursing Care–OAA), and 01 (Old Age Assistance-OAA);
- Individuals eligible under ME Codes 23 and 41 (MA ICF-MR Poverty) residing in a State Mental Institution or an Intermediate Care Facility for the Intellectually Disabled (ICF/ID);
- Individuals eligible under ME Codes 28, 49, and 67 (Children placed in foster homes or residential care by the Department of Mental Health);
- Pregnant women eligible under ME Code 58, 59, and 94, the Presumptive Eligibility Program for ambulatory prenatal care only;

- Individuals eligible under ME Codes 2, 3, 12, and 15 (Aid to the Blind and Blind Pension);
- AIDS Waiver participants (individuals twenty-one (21) years of age and over);
- Any individual eligible and receiving either or both Medicare Part A and Part B or Part C benefits;
- Individuals eligible under ME Codes 33 and 34 (MO Children with Developmental Disabilities Waiver);
- Individuals eligible under ME Code 55 (Qualified Medicare Beneficiary – QMB);
- Children eligible under ME Code 65, placed in residential care by their parents, if eligible for MO HealthNet on the date of placement;
- Uninsured women losing their MO HealthNet eligibility 60 days after the birth of their child would be eligible under ME Code 80 for women's health services for one year plus 60 days, regardless of income level;
- Women eligible for Women's Health Services, 1115 Waiver Demonstration, ME code 89. These are uninsured women who are at least 18 to 55 years of age, with a net family income at or below 185% of the Federal Poverty Level (FPL), and with assets totaling less than $250,000. These women are eligible for women's health services as long as they continue to meet eligibility requirements;
- Individuals with ME code 81 (Temporary Assignment Category);
- Individuals eligible under ME code 82 (MoRx);
- Women eligible under ME codes 83 and 84 (Breast and Cervical Cancer Treatment);
- Individuals eligible under ME code 87 (Presumptive Eligibility for Children); and
- Individuals eligible under ME code 88 (Voluntary Placement).

11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS

The MO HealthNet Managed Care Health Plans are required to provide health benefits to MO HealthNet Managed Care members for each date they are enrolled in the MO HealthNet Managed Care health plan. Managed Care members select a primary care provider (PCP) to provide routine care.

MO HealthNet enrolled providers (also called MO HealthNet Managed Care approved providers) who provide services to a Managed Care member do *not* receive direct reimbursement from the state for Managed Care health plan benefits furnished while the participant is enrolled in a MO HealthNet Managed Care health plan. MO HealthNet enrolled providers who wish to provide services for MO HealthNet Managed Care members *must* contact the Managed Care health plans for participation agreements/contracts or prior authorization.

The MO HealthNet Managed Care member *must* be told in advance of furnishing the service by the non- Managed Care health plan provider that they are able to receive the service from the MO HealthNet Managed Care health plan at no charge. The participant *must* sign a statement that they have been informed that the service is available through the Managed Care health plan but is being provided by the non- MO HealthNet Managed Care health plan provider and they are willing to pay for the service as a private pay patient.

MO HealthNet Managed Care health plan members receive the same standard benefit package regardless of the MO HealthNet Managed Care health plan they select. Managed Care health plans *must* provide services according to guidelines specified in contracts. Managed Care members are eligible for the same range of medical services as under the Fee-For-Service program. The Managed Care health plans may provide services directly, through subcontracts, or by referring the Managed Care member to a specialist. Services are provided according to the medical needs of the individual and within the scope of the Managed Care health plan's administration of health care benefits.

Some services continue to be provided outside the MO HealthNet Managed Care health plan with direct provider reimbursement by the MO HealthNet Division. Refer to Section 11.7.

11.6 STANDARD BENEFITS UNDER THE MO HEALTHNET MANAGED CARE PROGRAM

The following is a listing of the standard benefits under the comprehensive Managed Care Program. Benefits listed are limited to members who are eligible for the service.

- Inpatient hospital services
- Outpatient hospital services
- Emergency medical, behavioral health, and post-stabilization care services
- Ambulatory surgical center, birthing center
- Asthma education and in-home environmental assessments
- Physician services (including advanced practice nurse and certified nurse midwife)
- Family planning (requires freedom of choice and may be accessed out of the Managed Care Health Plan)
- Laboratory, radiology and other diagnostic services
- Maternity services (A shorter length of hospital stay for services related to maternity and newborn care may be authorized if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with federal and state law. Home visits are required following early discharge. Reference Section 13.20 of the Home Health Manual for more information)
- Prenatal case management
- Home health services
- Emergency (ground or air) transportation
- Nonemergency medical transportation (NEMT), except for CHIP children in ME Codes 73-75, and 97
- Services of other providers when referred by the Managed Care member's primary care provider
- Hospice services: Hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made.

- Durable medical equipment (including but *not* limited to orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs, walkers, diabetic supplies and equipment) and medically necessary equipment and supplies used in connection with physical, occupational, and speech therapies for all members with an Individualized Educational Program (IEP) or Individualized Family Service Plan (IFSP)
- Limited Podiatry services
- Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury; treatment of a disease/medical condition without which the health of the individual would be adversely affected; preventive services; restorative services; periodontal treatment; oral surgery; extractions; radiographs; pain evaluation and relief; infection control; and general anesthesia. Personal care/advanced personal care
- Optical services include one comprehensive or limited eye examination every two years for refractive error, services related to trauma or treatment of disease/medical condition (including eye prosthetics), one pair of eyeglasses every two years (during any 24 month period of time), and replacement lens(es) when there is a .50 or greater change.
- Services provided by local public health agencies (may be provided by the MO HealthNet Managed Care Health Plan or through the local public health agency and paid by the MO HealthNet Managed Care Health Plan)
    - Screening, diagnosis and treatment of sexually transmitted diseases
    - HIV screening and diagnostic services
    - Screening, diagnosis and treatment of tuberculosis
    - Childhood immunizations
    - Childhood lead poisoning prevention services, including screening, diagnosis and treatment
- Behavioral health services include mental health and substance use disorder services. Medically necessary behavioral health services are covered for children (except Group 4) and adults in all Managed Care regions. Services shall include, but *not* be limited to:
    - Inpatient hospitalization, when provided by an acute care hospital or a private or state psychiatric hospital
    - Outpatient services when provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed master social worker, licensed professional counselor, provisionally licensed professional counselor, licensed psychiatric clinical nurse specialist, licensed psychiatric nurse practitioner, or Missouri certified behavioral health programs
        - Crisis intervention/access services
        - Alternative services that are reasonable, cost effective and related to the member's treatment plan
        - Referral for screening to receive case management services.
        - Behavioral health services that are court ordered, 96 hour detentions, and for involuntary commitments.

- Behavioral health services to transition the Managed Care member who received behavioral health services from an out-of-network provider prior to enrollment with the MO HealthNet Managed Care health plan. The MO HealthNet Managed Care health plan shall authorize out-of-network providers to continue ongoing behavioral health and substance abuse treatment, services, and items for new Managed Care members until such time as the new Managed Care member has been transferred appropriately to the care of an in-network provider.

- Early, periodic, screening, diagnosis and treatment (EPSDT) services also known as healthy children and youth (HCY) services for individuals under the age of 21. Independent foster care adolescents with a Medical Eligibility code of 38 and who are ages twenty-one (21) through twenty-five (25) will receive a comprehensive benefit package for children in State care and custody; however, EPSDT screenings will no longer be covered. Services include but are *not* limited to:
  - HCY screens including interval history, unclothed physical, anticipatory guidance, lab/immunizations, lead screening (verbal risk assessment and blood lead levels, [mandatory 6-72 months]), developmental screen and vision, hearing, and dental screens
  - Orthodontics
  - Private duty nursing
  - Psychology/counseling services (Group 4 children in care and custody receive psychology/counseling services outside the Managed Care Health Plan). Refer to ME Codes listed for Group 4, Section 1.5.C
  - Physical, occupational and speech therapy (IEP and IFSP services may be accessed out of the MO HealthNet Managed Care health plan)
  - Expanded services in the Home Health, Optical, Personal Care, Hearing Aid and Durable Medical Equipment Programs
- Transplant-related services. The MO HealthNet Managed Care health plan is financially responsible for any inpatient, outpatient, physician, and related support services including pre-surgery assessment/evaluation prior to the date of the actual transplant surgery. The Managed Care Health Plan is responsible for the pre-transplant and post-transplant follow-up care.

11.6.A BENEFITS FOR CHILDREN AND WOMEN IN A MO HEALTHNET CATEGORY OF ASSISTANCE FOR PREGNANT WOMEN

A child is anyone less than 21 years of age. For some members the age limit may be less than 19 years of age. Some services need prior approval before they are provided. Women must be in a MO HealthNet category of assistance for pregnant women with ME codes 18, 43, 44, 45, 61 and targeted low-income pregnant women and unborn children who are eligible under Show-Me Healthy Babies with ME codes 95, 96, and 98 to receive these extra benefits.

- Comprehensive day rehabilitation, services to help with recovery from a serious head injury;
- Dental services – All preventive, diagnostic, and treatment services as outlined in the MO HealthNet State Plan;

- Diabetes self-management training for persons with gestational, Type I or Type II, diabetes;
- Hearing aids and related services;
- Optical services to include one (1) comprehensive or one (1) limited eye examination per year for refractive error, one (1) pair of eyeglasses every two years, replacement lens(es) when there is a .50 or greater change, and, for children under age 21, replacement frames and/or lenses when lost, broken or medically necessary, and HCY/EPSDT optical screen and services;
- Podiatry services;
- Services that are included in the comprehensive benefit package, medically necessary, and not identified in the IFSP or IEP.
- Therapy services (physical, occupational, and speech) that are not identified in an IEP or IFSP. This includes maintenance, developmental, and all other therapies.

11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE PROGRAM

The following services are available to MO HealthNet Managed Care members outside the MO HealthNet Managed Care Program and are reimbursed to MO HealthNet approved providers on a Fee-For-Service basis by the MO HealthNet Division:

- Abortion services (subject to MO HealthNet Program benefits and limitations)
- Adult Day Care Waiver
    - Home and Community based waiver services for Adult Day Care Services include but are not limited to assistance with activities of daily living, planned group activities, food services, client observation, skilled nursing services as specified in the plan of care, and transportation.
    - The health plan shall be responsible for MO HealthNet Managed Care comprehensive benefit package services for ADC waiver clients enrolled in MO HealthNet Managed Care, unless specifically excluded. The health plan shall be responsible for care coordination of services included in the comprehensive benefit package and the ADC waiver. Information regarding the ADC waiver services may be located on the DHSS website at: http://health.mo.gov/seniors/hcbs/adhcproposalpackets.php
- Physical, occupational and speech therapy services for children included in:
    - The Individual Education Plan (IEP); or
    - The Individual Family Service Plan (IFSP)
- Parents as Teachers
- Environmental lead assessments for children with elevated blood lead levels
- Community Psychiatric Rehabilitation program services
- Applied Behavior Analysis services for children with Autism Spectrum Disorder
- Comprehensive substance treatment and rehabilitation (CSTAR) services

- Laboratory tests performed by the Department of Health and Senior Services as required by law (e.g., metabolic testing for newborns)
- Newborn Screening Collection Kits
- Special Supplemental Nutrition for Women, Infants and Children (WIC) Program
- SAFE and CARE exams and related diagnostic studies furnished by a SAFE-CARE trained MO HealthNet approved provider

- Developmental Disabilities (DD) Waiver Services for DD waiver participants included in all Managed Care regions
- Transplant Services: The health plan shall coordinate services for a member requiring a transplant.
  - Solid organ and bone marrow/stem cell transplant services will be paid for all populations on a Fee-For-Service basis outside of the comprehensive benefit package.
  - Transplant services covered by Fee-For-Service are defined as the hospitalization from the date of transplant procedure until the date of discharge, including solid organ or bone marrow/stem cell procurement charges, and related physician services associated with both procurement and the transplant procedure.
  - The health plan shall not be responsible for the covered transplant but shall coordinate the pre- and post-transplant services.
- Behavioral health services for MO HealthNet Managed Care children (Group 4) in state care and custody
  - Inpatient services—patients with a dual diagnosis admission (physical and behavioral) have their hospital days covered by the MO HealthNet Managed Care Health Plan.
  - Outpatient behavioral health visits are *not* the responsibility of the MO HealthNet Managed Care Health Plan for Group 4 members when provided by a:
    - Licensed psychiatrist;
    - Licensed psychologist, provisionally licensed psychologist, licensed clinical social worker, licensed master social worker, licensed professional counselor or provisionally licensed professional counselor ;
    - Psychiatric Clinical Nurse Specialist, Psychiatric Mental Health Nurse Practitioner state certified behavioral health or substance abuse program; or
    - A qualified behavioral health professional in the following settings:
      - Federally qualified health center (FQHC); and
      - Rural health clinic (RHC).
- Pharmacy services.
- Home birth services.
- Targeted Case Management for Behavioral Health Services.

11.8 QUALITY OF CARE

The state has developed quality improvement measures for the MO HealthNet Managed Care Health Plan and will monitor their performance.

11.9 IDENTIFICATION OF MO HEALTHNET MANAGED CARE PARTICIPANTS

Participants who are included in the MO HealthNet Managed Care Program are identified on eMOMED or the IVR system when verifying eligibility. The response received identifies the name and telephone number of the participant's selected MO HealthNet Managed Care health plan. For MO HealthNet Managed Care members, the response also includes the identity of the MO HealthNet Managed Care member's primary care provider (PCP). For providers who need to contact the PCP, they may contact the Managed Care health plan to confirm the PCP on the state's system has not recently changed. Participants who are eligible for the MO HealthNet Managed Care Program and enrolled with a MO HealthNet Managed Care health plan *must* have their basic benefit services provided by or prior authorized by the MO HealthNet Managed Care health plan. Refer to Section 1 for additional information on identification of participants in MO HealthNet Managed Care Programs.

MO HealthNet Managed Care health plans may also issue their own individual Managed Care health plan ID cards. The individual *must* be eligible for the Managed Care Program and enrolled with the MO HealthNet Managed Care health plan on the date of service for the MO HealthNet Managed Care health plan to be responsible for services. Providers *must* verify the eligibility status and Managed Care health plan enrollment status on all MO HealthNet Managed Care participants before providing service.

11.9.A NON-BILLING MO HEALTHNET PROVIDER

MO HealthNet Managed Care health plan providers who have a valid agreement with one or more Managed Care health plans but who are *not* enrolled as a participating MO HealthNet provider may access eMOMED or the Interactive Voice Response (IVR) only if they enroll with MO HealthNet as a "Non-Billing MO HealthNet Provider." Providers are issued an atypical provider identifier that permits access to eMOMED or the IVR; however, it is *not* valid for billing MO HealthNet on a Fee-For-Service basis. Information regarding enrollment as a "Non-Billing MO HealthNet Provider" can be obtained by contacting the Provider Enrollment Unit at mmac.providerenrollment@dss.mo.gov.

11.10 EMERGENCY SERVICES

Emergency medical/behavioral health services means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and are needed to evaluate or stabilize an emergency medical condition.

Emergency medical condition for MO HealthNet Managed Care health plan members means medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or

2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery or; (2) that transfer may pose a threat to the health or safety of the woman or the unborn.

Post stabilization care services means covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized conditions or to improve or resolve the member's condition.

11.11 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a comprehensive service delivery system and finance model for the frail elderly that replicates the original model pioneered at the San Francisco On Lok site in the early 1980s. The fully capitated service delivery system includes: primary care, restorative therapy, transportation, home health care, inpatient acute care, and nursing facility long-term care when home and community-based services are no longer appropriate. Services are provided at the PACE center, the home, in the hospital, or in a nursing facility, depending upon the needs of the individual. The goal is to maximize each participant's potential and continued residence in the home and community by providing preventive primary care and other support. Enrollment in the PACE program is always voluntary. Participants have the option to disenroll and return to the Fee-For-Service system at any time. A fully capitated PACE provider receives a monthly capitation from Medicare and/or MO HealthNet. All medical services that the individual requires while enrolled in the program are the financial responsibility of the fully capitated PACE provider. A successful PACE site serves 150 to 300 enrollees in a limited geographical area. The Balanced Budget Act of 1997 established PACE as a permanent provider under Medicare and allowed states the option to pay for PACE services under MO HealthNet.

11.11.A ELIGIBILITY FOR PACE

Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive service delivery system and finance model for the frail elderly. The PACE Organization provides a full range of preventive, primary, acute, and long-term care services 24 hours per day, 7 days per week to PACE participants. Services are provided at the PACE center, the home, in the hospital, or in a nursing facility, depending upon the needs of the participant. All medical services that the participant requires, while enrolled in the program, are the financial responsibility of the PACE provider. Enrollment in a PACE program is always voluntary. Participants have the option to disenroll and return to the Fee-For-Service system at any time.

The Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS), is the entry point for referrals to the PACE provider and assessments for PACE program eligibility. Referrals for the program may be made to DSDS by completing the PACE Referral/Assessment form and faxing to the DSDS Call Center at 314/877-2292 or by

calling toll free at 866/835-3505. The PACE Referral/Assessment form can be located at http://health.mo.gov/seniors/hcbs/hcbsmanual/index.php.

The target population for this program includes individuals age 55 and older, identified by DHSS through a health status assessment with a score of at least 21 points on the nursing home level of care assessment; and who reside in the service area.

11.11.B INDIVIDUALS NOT ELIGIBLE FOR PACE

Individuals *not* eligible for PACE enrollment include:

- Persons who are under age 55;
- Persons residing in a State Mental Institution or Intermediate Care Facility for the Intellectually Disabled (ICF/ID);
- Persons enrolled in the Managed Care Program; and
- Persons currently enrolled with a MO HealthNet hospice provider.

11.11.C LOCK-IN IDENTIFICATION OF PACE INDIVIDUALS

When a DHSS-assessed individual meets the program criteria and chooses to enroll in the PACE program, the PACE provider has the individual sign an enrollment agreement and the DHSS locks the individual into the PACE provider for covered PACE services. All services are provided solely through the PACE provider. Lock-in information is available to providers through eMOMED and the IVR at (573) 751-2896. Enrollment in a PACE program is always voluntary and participants have the option to disenroll and return to the Fee-For-Service system at any time.

11.11.D PACE COVERED SERVICES

Once the individual is locked into the PACE provider, the PACE provider is responsible for providing the following covered PACE services:

- Physician, clinic, advanced practice nurse, and specialist (ophthalmology, podiatry, audiology, internist, surgeon, neurology, etc.);
- Nursing facility services;
- Physical, occupational, and speech therapies (group or individual);
- Non-emergency medical transportation (including door-to-door services and the ability to provide for a companion to travel with the client when medically necessary);
- Emergency transportation;
- Adult day health care services;
- Optometry and ophthalmology services including eye exams, eyeglasses, prosthetic eyes, and other eye appliances;
- Audiology services including hearing aids and hearing aid services;

- Dental services including dentures;
- Mental health and substance abuse services including community psychiatric rehabilitation services;
- Oxygen, prosthetic and orthotic supplies, durable medical equipment and medical appliances;
- Health promotion and disease prevention services/primary medical care;
- In-home supportive care such as homemaker/chore, personal care and in-home nutrition;
- Pharmaceutical services, prescribed drugs, and over the counter medications;
- Medical and surgical specialty and consultation services;
- Home health services;
- Inpatient and outpatient hospital services;
- Services for chronic renal dialysis chronic maintenance dialysis treatment, and dialysis supplies;
- Emergency room care and treatment room services;
- Laboratory, radiology, and radioisotope services, lab tests performed by DHSS and required by law;
- Interdisciplinary assessment and treatment planning;
- Nutritional counseling;
- Recreational therapy;
- Meals;
- Case management, care coordination;
- Rehabilitation services;
- Hospice services;
- Ambulatory surgical center services; and
- Other services determined necessary by the interdisciplinary team to improve and maintain the participants overall health status.

No Fee-For-Service claims are reimbursed by MO HealthNet for participants enrolled in PACE. Services authorized by MHD prior to the effective enrollment date with the PACE provider are the responsibility of MHD. All other prior authorized services *must* be arranged for or provided by the PACE provider and are *not* reimbursed through Fee-For-Service.

END OF SECTION

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SECTION 12—REIMBURSEMENT METHODOLOGY

12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT

The MO HealthNet Division (MHD) is charged with establishing and administering the rate of payment for those medical services covered by the Missouri Title XIX Program. The MHD establishes a rate of payment that meets the following goals:

- Ensures access to quality medical care for all participants by encouraging a sufficient number of providers;
- Allows for no adverse impact on private-pay patients;
- Assures a reasonable rate to protect the interests of the taxpayers; and
- Provides incentives that encourage efficiency on the part of medical providers.

Funds used to reimburse providers for services rendered to eligible participants are received in part from federal funds and supplemented by state funds to cover the costs. The amount of funding by the federal government is based on a percentage of the allowable expenditures. The percentage varies from program to program and in some cases different percentages for some services within the same program may apply. Funding from the federal government may be as little as 60% or as much as 90%, depending on the service and/or program. The balance of the allowable (10-40%) is paid from state General Revenue appropriated funds.

Under a fee system, each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established. The MHD determines a maximum allowable fee for the services based upon all applicable information and current appropriated funds:

- Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee and/or stakeholders;
- Medicare's allowable reasonable and customary charge payment or cost-related payment;
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public. Implicit in the use of charges as the basis for fees is the objective that charges for services be related to the cost of providing the services.

Total expenditures for MO HealthNet *must* be within the appropriation limits established by the General Assembly. If the expenditures do *not* stay within the appropriation limits set by the General Assembly and funds are insufficient to pay the full amount, then the payment for services may be reduced pro rata in proportion to the deficiency.

12.2 PERSONAL CARE SERVICES

Reimbursement for personal care services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the State Medicaid Agency to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service), or the maximum allowable per unit of service.

12.3 ONLINE FEE SCHEDULE

MO HealthNet fee schedules are available online at: http://www.dss.mo.gov/mhd/providers/index.htm. The fee schedule identifies covered and non-covered procedure codes, restrictions, allowed units and the Medicaid allowable fee per unit. The fee schedule is updated quarterly and is intended as a reference *not* a guarantee for payment.

The online fee schedule allows for the downloading of individual files or the search for a specific fee schedule. Some procedure codes may be billed by multiple provider types. Categories within the fee schedule are set up by the service rendered and are *not* necessarily provider specific.

Refer to Section 13 for program specific benefits and limitations.

12.4 MEDICARE/MEDICAID REIMBURSEMENT (CROSSOVER CLAIMS)

For MO HealthNet participants who are also Medicare beneficiaries and receive services covered by the Medicare Program, MO HealthNet pays the deductible and coinsurance amounts otherwise charged to the participant by the provider. This does *not* apply to the Personal Care Program.

12.5 PARTICIPANT COST SHARING AND COPAY

Certain MO HealthNet services are subject to participant cost sharing or copay. The cost sharing amount is paid by the participant at the time services are rendered. Services of the Personal Care Program described in this manual are *not* subject to a cost sharing or copay amount.

12.6 A MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT

One method through which MO HealthNet provides services is a Managed Health Care Delivery System. A basic package of services is offered to the participant by the health plan; however, some services are *not* included and are covered by MO HealthNet on a fee-for-service basis.

Personal care services are included as a plan benefit in Missouri's Managed Care Program for children under the age of 21 unless they are included in an Individualized Education Program (IEP) developed by the Public School. Adults assessed at a nursing home level of care are considered eligible for personal care service from the health plan.

12.6.A MANAGED HEALTH CARE

Under a managed health plan, a basic set of services is provided either directly or through subcontractors. Managed health care plans are reimbursed at an established rate per member per month. Reimbursement is based on predicted need for health care and is paid for each participant for each month of coverage. Rather than setting a reimbursement rate for each unit of service, the total reimbursement for all enrollees for the month *must* provide for all needed health care to all participants in the group covered.

The health plan is at risk for staying within the *overall* budget—that is, within the negotiated rate per member per month multiplied by the number of participants covered. Some individual cases exceed the negotiated rate per member per month but many more cases cost less than the negotiated rate.

The Medicaid Program utilizes the managed care delivery system for certain included Medicaid eligibles. Refer to Section 1 and Section 11 for a detailed description.

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SECTION 13-BENEFITS AND LIMITATIONS

13.1 GENERAL INFORMATION

The Missouri Title XIX (Medicaid) Personal Care Program offers medically related services designed to meet the maintenance needs of participants with a chronic, stable condition. Available services include: basic and advanced personal care, personal care assistance consumer-directed services, and authorized nurse visits. Personal Care Assistance Consumer-Directed service requirements can be found in Section 13.10 of this manual.

The purpose of the authorized nurse visit is to provide increased supervision to the personal care aide, intensified health care assessment of the participant, and in some cases, certain nursing services that do *not* meet the requirements for reimbursement under either the Medicare or MO HealthNet Home Health Programs. The authorized nurse visit is used for advanced personal care plan development, on-the-job training for the advanced personal care aide, and monthly evaluation of advanced personal care participants.

A description of the services and requirements of this program is included later in this section.

13.1.A SERVICE DEFINITION

Personal care services are medically oriented tasks provided in the individual's home that are approved by the state or reviewed and approved as certified by a physician as the home care necessary to meet a participant's physical needs. This enables the participant to remain in his or her home and be treated on an outpatient basis rather than in a hospital or nursing facility. The requirement of physician's approval versus physician's certification is dependent upon which participant group (e.g., elderly, children, etc.) the personal care services are being authorized for. Reference the authorization section applicable to each participant group. For purposes of the Personal Care Program, the term "home" includes participants residing in Residential Care Facilities or Assisted Living Facilities. These services *must* be reasonable and necessary for the treatment of a medical condition and *must* maintain or increase the functional capacity of the participant. Personal care services are intended to meet personal, physical requirements, as opposed to general housekeeping requirements, and to meet needs that *cannot* be met by other resources. Personal care services covered by the Missouri Title XIX (Medicaid) Program *must* be provided by a qualified individual who is *not* a member of the participant's family.

NOTE: A family member is defined as a parent; sibling; child by blood, adoption, or marriage; spouse; grandparent; or grandchild.

13.1.B PERSONAL CARE TASKS

Examples of personal care services that may be performed are:

- Planning, preparation, and clean-up of meals;
- Making beds and changing sheets with the participant in or out of the bed, as required;
- Brushing, combing and shampooing hair;

- Giving bed baths and assisting with other baths;
- Brushing teeth and cleaning dentures when the participant is unable;
- Cleaning and cutting fingernails and toenails of participants without contraindicating conditions;
- Shaving with an electric or safety razor, as appropriate; an electric razor *must* be used for the diabetic participant or participant with contraindicating conditions;
- Giving assistance to and from the bed to a wheelchair, walker or chair when a participant is weight bearing;
- Assisting the participant with ordinarily self-administered medications (open bottles, get water);
- Shopping for groceries or household items specifically required for the health and maintenance of the participant; and
- Applying non-prescription topical ointments/lotions to unbroken skin at the participant's direction.

The encouragement and instruction of participants in self-care may be a component of any other task(s) as described above; however, encouragement and instruction do *not* constitute a task in and of themselves.

Advanced personal care services provide assistance with activities of daily living when such assistance requires devices and procedures related to altered body functions. These services are described in greater detail later in Section 13.9.

13.1.C SERVICE LIMITATIONS

Personal care services are covered only in the participant's home; by definition, this includes Residential Care Facilities and Assisted Living Facilities. These services are *not* covered in a hospital or nursing facility. The only acceptable place of service code to use when filing claims is 12 (Home).

Personal care providers are *not* reimbursed for the following activities:

- Providing therapeutic/health-related activities that should be performed by an RN, LPN, or home health aide under Title XVIII or Title XIX Home Health Programs;
- Providing transportation;
- Accompanying the participant outside of the home;
- Administering patent or prescribed medications;
- Cleaning or cutting fingernails or toenails of a diabetic participant or a participant with medically contraindicating conditions (i.e., participants taking anticoagulant medication, those diagnosed with a peripheral vascular disease or have a compromised immune system), unless this service is performed by a nurse during an authorized nurse visit;
- Cleaning the floor and furniture in areas *not* occupied by the participant. For example, cleaning the entire living area if the participant occupies only one small room;

- Cleaning spaces shared by members of the entire household;
- When the task is one that members of a household may reasonably be expected to share or do for one another, unless the task is above and beyond typical activities that would be provided for a household member without a disability;
- Laundry, other than that incidental to the care of the participant. For example, laundering clothing and bedding for the entire household, as opposed to simple laundering of the participant's bed smock or gown;
- Shopping for groceries or household items other than items required specifically for the health and maintenance of the participant. This does *not* preclude a personal care aide shopping for items needed by the participant, but also used by the rest of the household;
- Providing personal care services to a participant by a member of the participant's family or household member; and
- Performing or furnishing out-of-state personal care services.

13.1.D PROVIDER PARTICIPATION

The provider of personal care services must have a valid MO HealthNet Personal Care Provider Agreement in effect with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance Unit (MMAC).

The applicant to provide personal care services must be one of the following to enroll:

- An approved Department of Social Services (DSS), MMAC Title XX Social Services Block Grant/General Revenue (SSBG)/(GR) provider. Providers *must* maintain their approval to participate as an SSBG/GR provider, whether or not they actually service SSBG/GR eligible participants.
- A Residential Care Facility (RCF) or Assisted Living Facility (ALF) , licensed by the Department of Health and Senior Services, Division of Regulation and Licensure. RCF/ALF personal care providers may only furnish personal care services to participants in their RCF/ALF. MO HealthNet RCF/ALF personal care providers must maintain their RCF/ALF license.

13.1.E PARTICIPANT ELIGIBILITY FOR PERSONAL CARE SERVICES

Eligibility for personal care services requires current eligibility for MO HealthNet. In addition to being MO HealthNet eligible, the participant *must*:

- be assessed by the appropriate state agency or its designee (reference Section 14.1) to have certain impairments and unmet needs, such that the participant would require admission to a hospital or a long term care facility if personal care services were not provided; and

- be willing to receive comprehensive assessment from the involved state agency or its designee.

The participant *must* be eligible for MO HealthNet services on the day the service is delivered, or the provider will *not* be reimbursed through MO HealthNet. This is a requirement even when the service has been prior authorized. It is the responsibility of the provider to verify eligibility by contacting the interactive voice response unit (IVR) system at (573) 635-8908 or online at www.emomed.com.

13.1.F AUTHORIZATION OF PERSONAL CARE SERVICES

All units of Title XIX personal care services *must* be authorized by qualified state agency or its designee staff before services can be delivered.

Documentation requirements are contained in Section 14 of this Manual.

13.1.G COORDINATION OF PERSONAL CARE WITH DIVISION OF DEVELOPMENTAL DISABILITIES WAIVER PERSONAL ASSISTANCE

The Missouri Department of Mental Health (DMH), Division of Developmental Disabilities (DD), operates five Home and Community-based Waivers for people with developmental disabilities. All five waivers include personal assistance, including the option for self - or family-directed waiver personal assistance.

The Centers for Medicare and Medicaid Services (CMS) does not allow waiver services to duplicate or supplant services covered in the Medicaid state plan, and requires that when a service is available under the Medicaid state plan, the waiver may provide services beyond the scope of the state plan.

Participants of any DD Waiver who are also eligible for state plan personal care may also receive waiver personal assistance in these situations:

- State plan limits on number of units for personal care are reached and more assistance with ADLs and/or IADLs is needed;
- Person requires personal assistance at locations outside of their residence;
- The individual has behavioral or medical needs and they require a more highly trained personal assistant than is available under state plan;
- When the individual or family is directing waiver personal assistant services through a DD Fiscal Management Services contractor.

When individuals receive both state plan personal assistance and DD waiver personal assistance, the DHSS service authorization system must coordinate closely with the local DD support coordinator.

13.2 ADMINISTRATION

13.2.A PARTICIPATION AND NOTIFICATION REQUIREMENTS

The following administrative standards *must* be followed whenever personal care services or authorized nurse visits are being delivered.

- Each participating provider *must* have a valid MO HealthNet Personal Care agreement in effect with the (MMAC).
- The provider shall immediately notify the MMAC of any changes in location, telephone number, administrative, or corporate status by using a Change Request Form.
- The provider shall notify MMAC at least 30 days prior to the termination of the provider agreement.

13.2.B PERSONNEL—GENERAL ADMINISTRATIVE REQUIREMENTS

- The provider *must* document all staff qualifications in the personnel records, such as verification of the registered nurse or licensed practical nurse license, or certified nurse assistant , which should include at least the license or certification number.
- The provider shall maintain documentation of at least two employment or personal references contacted for each personal care aide within 30 calendar days from the date of employment. References shall be former employers or other reputable persons, excluding relatives of the personal care aide. The documentation shall include the name of the employer and the individual giving the reference, the date, the response given when the reference was obtained by telephone and the signature of the person receiving the reference.
- The provider shall establish, implement and enforce a policy governing communicable diseases that prohibits provider staff contact with participants when the employee has a communicable condition, including colds or flu. Ensure that reporting requirements governing communicable diseases, including hepatitis and tuberculosis, as set by the Missouri Department of Health and Senior Services (19 CSR 20-20.020), are carried out.
- The provider *must* have an established grievance system through which a participant may present grievances concerning the operation of the personal care program. The provider *must* document the participant's receipt of information regarding the grievance procedures.
- The provider *must* protect the Departments of Social Services and Health and Senior Services and their employees, agents, or representatives from any and all liability, loss, damage, cost and expense which may accrue or be sustained by the Departments of

Social Services and Health and Senior Services, its officers, agents or employees as a result of claims, demands, costs, suits or judgments against it arising from the loss, injury, destruction or damage, either to person or property, sustained in connection with the performance of the personal care program.

- Providers *must* establish, enforce and implement a policy whereby all contents of the personnel files of its employees are made available to Departments of Social Services and Health and Senior Services employees or representatives when requested as part of an official investigation of abuse, neglect, financial exploitation, misappropriation of participant's funds or property, or falsification of documentation which verifies service delivery.
- The provider shall maintain bonding and personal and property liability insurance coverage on all employees and volunteers who are involved in delivering personal care services.
- The provider shall ensure that all employees are registered with the Department of Health and Senior Services' (DHSS) Family Care Safety Registry (FCSR).. The provider shall then request background information on all employees and abide by the rules set forth in 19 CSR 30-82.060 regarding any employees not eligible for employment.
- The provider shall conduct a criminal back-ground screening as required in 192.2495, RSMo.
- The provider *must* check the DHSS Employee Disqualification List (EDL) or the Family Care Safety Registry (FCSR), prior to employment for prospective employees, to assure their names do not appear on the list. This may be accomplished by calling the DHSS Interactive Voice Response (IVR) system at (573) 522-6510 or by accessing the Internet at http://www.dhss.mo.gov/safety/edl/. These automated systems will allow verification of the EDL status of applicants for employment, or current employees, and provide a confirmation number verifying that the required EDL check was performed. The systems are available for calls and website visits seven (7) days a week, twenty-two (22) hours per day. System maintenance occurs between 2:00 a.m. and 4:00 a.m., each day.
- The provider must take the appropriate action once it is discovered by the provider that the current employee is on the EDL. If it is found that a prospective employee is on the EDL , then that employee must not be considered further for employment.
- Providers using the FCSR, available on the Internet at http://health.mo.gov/safety/fcsr/index.php, to conduct the EDL and criminal back-ground screenings meet the statutory background screening requirements, provided

there is sufficient documentation showing the identity of the person who was screened, the dates the screening was required and completed, and the outcome of the screening.

- Providers are encouraged to check each employee monthly against the Office of Inspector General's List of Excluded Individuals/Entities (LEIE) for current employees and prior to employment for prospective employees. All employee background screenings must be retained by the provider either electronically or in paper form and must be made available upon request by MMAC, DHSS or Social Service's staff.
- The provider *must* issue to each personal care aide, at time of employment, a permanent identification card that shows the provider's name and the aide's name and title. The provider shall require each personal care aide to carry the identification card to present to participants as necessary. The provider shall make every effort to repossess the I.D. card upon termination of employment. If unable to do so, the provider *must* retain on file a statement describing what efforts were made to recover the I.D. card.

13.2.C PROVIDER SERVICE DELIVERY STANDARDS

- The provider *must* have the capability to provide service outside of regular business hours, on weekends, and on holidays to provide services in accordance with the care plan for each participant. Service *must* be provided by qualified persons on the provider's staff.
- Providers shall accept participants on the basis of a reasonable expectation that the participant's maintenance care needs can be met adequately by the provider in the participant's place of residence. Services *must* follow the care plan.
- The provider *must* deliver the personal care services within seven (7) calendar days of receipt of the service authorization notification or on the beginning date specified by the authorization, whichever is later, and on a regular basis thereafter in accordance with the care plan. If service is *not* initiated within the required time period, a detailed written justification *must* be maintained in the participant's file. Providers are encouraged to upload the justification into the HCBS Web Tool, a component of CyberAccess.
- The personal care provider *must* report all instances of potential abuse, neglect, and/or exploitation of a participant to the appropriate state agency, including all instances that may involve an employee of the provider.

13.2.D PARTICIPANT'S RIGHTS AND PROCEDURES

The provider shall have a written statement of the participant's rights which is to be given to each participant and primary caregiver, when appropriate, at the time service is initiated, which includes, at a minimum, the right to:

- be treated with respect and dignity;
- have all personal and medical information kept confidential;
- have direction over the services provided, to the degree possible, within the care plan authorized;
- know the provider's established grievance procedure, how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution;
- receive service without regard to race, creed, color, age, sex, or national origin; and
- receive a copy of the code of ethics under which services are provided.

13.2.D(1) Participant Nonliability

MO HealthNet covered services rendered to an eligible beneficiary are *not* billable to the beneficiary if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

For questions regarding the Personal Care Program, call the Provider Relations Communication Unit's number (573) 751-2896.

13.2.D(2) Participant Cost Sharing and Copay

Participants eligible to receive certain MO HealthNet services are required to pay a small portion of the cost of the services. Services of the Personal Care Program described in this manual are *not* subject to a cost sharing or copay amount.

13.2.E DISCHARGE POLICIES AND PROCEDURES

Services for a participant shall be discontinued by a provider under the following circumstances:

- When the participant's case is closed by the state agency or its designee;
- When the provider learns of circumstances that require the closure of a case for reasons including, but *not* limited to: death; entry into a nursing facility; or the participant no longer needs services. In these circumstances, the provider shall notify the state agency or its designee in writing and request that the participant's services be discontinued;

- When the participant is noncompliant with the agreed upon care plan. Noncompliance requires persistent actions by the participant, friends, or family which negate the services delivered by the provider. After all alternatives have been explored and exhausted, the provider shall notify the state agency or its designee, in writing, of the noncompliant acts and request that the participant's services be discontinued;
- When the participant or participant's family threatens or abuses the personal care aide or other provider staff to the point where the staff's welfare is in jeopardy and corrective action has failed. The provider shall notify the state agency or its designee of the threatening or abusive acts and may request that the service authorization be discontinued;
- When a provider is unable to continue to meet the maintenance needs of a participant. In these circumstances, the provider shall notify the state agency or its designee, in writing, and request that the participant's services be discontinued; or
- When a provider is unable to continue to meet the maintenance needs of a participant or when a participant is noncompliant with the agreed upon care plan, the provider shall provide written notice of discharge to the participant or participant's family and the state agency or its designee, at least 21 days prior to the date of discharge. During this 21 day period, the state agency or its designee shall assist in making appropriate arrangements with the participant for transfer to another provider, institutional placement, or other appropriate care. Regardless of circumstances, the personal care provider must continue to provide care in accordance with the plan of care for these 21 days or until alternate arrangements can be made by the state agency, or its designee, whichever comes first.

Discontinuing services for a participant still in need of assistance shall occur only after appropriate conferences with the state agency or its designee, participant and participant's family.

13.2.F PROVIDER COMPLIANCE

The Departments of Social Services and Health and Senior Services or their designee conduct both program and fiscal monitoring of the Personal Care Program. Monitoring visits may be announced or unannounced. The providers *must* agree to comply with any reviews conducted by the Departments of Social Services and Health and Senior Services or their designee. The Division of Senior and Disability Services may, in accordance with the protective service mandate (Chapter 192, RSMo), take action to protect participants from providers who are found to be out of compliance with statutory and regulatory requirements applicable to the Personal Care Program, when such noncompliance is determined by the Division of Senior and Disability Services to create a risk of injury or harm to participants.

13.3 PERSONNEL

13.3.A ADMINISTRATIVE SUPERVISOR QUALIFICATIONS

A personal care administrative supervisor shall be designated by the provider ownership or administrative management to supervise the day to day delivery of direct personal care services. This position of responsibility may be assigned in conjunction with other duties within the provider organization.

The designated administrative supervisor shall be at least 21 years of age. In addition, the supervisor must meet at least one of the following criteria before performing the supervisory duties required by these standards. The supervisor *must*:

- be a registered nurse (RN) licensed in the state of Missouri; or
- have a baccalaureate degree; or
- be a licensed practical nurse (LPN), licensed in the state of Missouri with at least one year of experience with the direct care of the elderly, disabled, or infirm; or
- have three years of experience in the care of the elderly, disabled or infirm.

If the designated administrative supervisor is not a registered nurse (RN), the provider agency must have an RN on staff or employed as a consultant available to fulfill the specific functions described later in this section. The RN must be currently licensed in the state of Missouri.

13.3.B PERSONAL CARE AIDE REQUIREMENTS

All basic personal care aides employed by the provider *must*:

- be at least 18 years of age;
- be able to read, write and follow directions; and
- have at least six (6) months paid work experience as an agency homemaker, nurse aide, maid or household worker, or at least one (1) year of experience in caring for children or for sick or aged individuals. Successful completion of formal training in the nursing arts, such as a nursing aide or home health aide, may be substituted for the qualifying experience. This information must be verified and documented in the employee's file through reference checks of past paid or unpaid employers. Advanced personal care aides must have additional qualification, as discussed in Section 13.9.
- not be the family member of the participant for whom personal care is to be provided. Family member is defined as a parent; sibling, child by blood, adoption or marriage; spouse; grandparent or grandchild.

13.4 SUPERVISION

13.4.A GENERAL ADMINISTRATIVE DUTIES

The duties of the designated administrative supervisor include the following:

- Read a copy of the MO HealthNet Program requirements contained in Section 13 of the provider manual. All nursing staff (registered nurses and licensed practical nurses) and administrative supervisors *must* have documentation in their personnel files that they have been given and have read this section.
- Monitor the provision of personal care services and authorized nurse visits to ensure that services are delivered in accordance with the services authorized by the appropriate state agency or its designee. This shall include routine review and comparison of the aides' records of provided services with the service authorizations for each participant. The units of service authorized, the tasks specified, and the authorized frequency of delivery *must* be compared to the units, tasks, and frequency of delivered services. A written explanation of any discrepancies and description of any action taken must be signed and dated by the supervisor and be readily available for monitoring or inspection. This requirement shall be met by a supervisory monitoring/delivery log document, (refer to Section 14.2) which must be completed monthly. One log for each county served shall be sent to the Division of Senior Services Regional Manager or the Bureau of Special Health Care Needs office in charge of care coordination for that participant whose region includes the counties served. It is due by the thirtieth day of each month immediately following the month of the log. A copy of each log shall be kept by the provider and be available for monitoring, upon the request by the Departments of Social Services or Health and Senior Services or MMAC Refer to Section 14 for more information regarding this document.
- Complete a written evaluation of each personal care aide's performance at least annually. The evaluation *must* be based in part on at least one on-site visit. The on-site visit also includes an evaluation of the adequacy of the care plan, including review of the care plan with the participant, and the aide's ability to complete the tasks in the care plan. The aide *must* be present during the visit, and documentation *must* be provided to indicate the aide's presence. The written report of the evaluation should document the visit, containing the participant's name and address, the date and time of the visit, the aide's name, and the supervisor's observations and notes from the visit. In addition to information from the on-site visit, the written evaluation should contain sufficient other data on the aide's performance to demonstrate that the evaluation was based on qualified observation. The written evaluation should show what support and supervision has been provided to the aide and what support, supervision, and other

intervention is planned as a result of the evaluation. The evaluation *must* be signed and dated by the supervisor who prepared it and by the aide.

The written record of the evaluation shall be maintained in the personnel file of the personal care aide. If the required evaluation is *not* performed or *not* documented, the personal care aide's qualifications to provide the service may be presumed inadequate and all payments made for services by that personal care aide may be recouped. Unless, medically, the participant's condition supports a visit or all participants have been visited, a service participant shall not receive more than one combined on-site supervisory visit and on-site RN visit per state fiscal year.

- Assist in orientation and personal care training for personal care aides.
- Designate a trainer(s) to perform on-the-job training sessions required as part of the basic training of the personal care aide. (Refer to Section 13.6.) The designated trainer(s) may be the personal care supervisor or a personal care aide who has been employed by a personal care provider at least half-time for a period of six months.
- Communicate with the state agency, or its designee, regarding changes in any participant's condition and recommended changes in scope or frequency of service delivery. The provider *must* document in the participant file such communication.
- Be available for regular case conferences with the appropriate state agency or its designee.

13.5 NURSE SUPERVISION REQUIREMENTS

13.5.A PARTICIPANT SAMPLING

Registered nurse supervision of personal care services is a requirement of the MO HealthNet Personal Care Program. Each MO HealthNet Personal Care provider must have an RN available to perform specific supervisory functions. While some of the nursing supervision functions may be delegated to a licensed practical nurse, as described in this section, the provider is still responsible for having registered nurse staff available to perform specified supervisory tasks. Depending upon the size and administrative structure of the provider, the registered nurse may also be the designated administrative supervisor, described in Section 13.3.A.

To meet this supervisory responsibility, a monthly home visit shall be made to a 10% sample of the provider's agency's combined Title XIX and Title XX caseload size as of the beginning of each month, except that no more than 30 visits and no less than 2 visits are required. This 10% sample is to exclude personal care and advanced personal care participants receiving authorized nurse visits and on-site supervisory visits during that same month unless all participants have been seen or the participant's condition supports a visit. The agency provider should develop sampling methods to ensure that as many individuals as

possible may be seen during the course of a year. Providers should avoid choosing the same participants for a supervisory visit month after month unless their level of care needs warrant frequent supervisory visits. The RN shall visit the participant at home or determine that an LPN will make the visit based upon the types of personal care services authorized in the participant's plan of care.

The RN has the responsibility of evaluating the adequacy of the plan of care in meeting the participant's needs, and shall include a review of the plan of care with the participant and assessment of the personal care worker relative to his/her ability to carry out the plan of care.

Written notes concerning the on-site visit must be maintained in the participant's case record. In addition, the RN must keep an on-site visiting log that lists, for each visit, the service participant's name, address, the date of the visit, the personal care worker's name and observations of both the personal care worker's performance and the adequacy of the service plan.

If the provider's designated administrative supervisor is not an RN, the staff RN or the RN consultant shall initial and review all on-site visit reports made by the designated administrative supervisor.

If supervised by an RN, an LPN may perform the RN supervisory activities described in this section.

13.6 TRAINING

All personal care aides, whether basic or advanced personal care aides, who provide services reimbursed by MO HealthNet *must* meet or have met the basic training and in-service training standards set forth in this section. Advanced personal care aides have additional training requirements, discussed under Advanced Personal Care in Section 13.9.The cost of all training is part of the provider's administrative cost and is not separately billable.

13.6.A DOCUMENTATION OF BASIC AND IN-SERVICE TRAINING

The provider shall have written plans for basic and in-service training of the personal care aide. These plans should include content for sessions. The plans should be updated as needed, to reflect the training needs of the provider's personal care aides, as well as, to incorporate any changes in the standards for Title XIX services.

The provider *must* maintain a report of each individual personal care aide's training in that aide's personnel record. The report *must* document the dates, hours and location of classroom and on-the-job training, the trainer's name, the topics, the date of first participant contact, and the aide's signature. Participant contact may be either supervised on-the-job training or unsupervised service delivery. If a waiver of basic training has been granted, the personal care aide's individual training report shall contain supportive data for the waiver.

Other required documentation includes a topical outline of each session's content, the mode of training (classroom or on-the-job), and the signature of the attendee(s). Deviations in content from the written plan should be noted and explained.

The documentation referenced in the above paragraph may be maintained in a master training log or may be filed in each personal care aide's personnel file. The documentation *must* be readily available for monitoring or inspection by the Departments of Social Services and Health and Senior Services.

13.6.B BASIC TRAINING

When individuals are employed as personal care aides, they shall receive a minimum of 20 hours of basic training. The following requirements apply to this training.

- All basic training *must* be completed within 30 days of the first date of employment.
- 8 hours of classroom training *must* be completed prior to first participant contact.
- 2 hours of basic training *must* include orientation to the provider and the provider's protocols for handling emergencies.
- Reading materials shall constitute no more than 2 of the total 20 hours.

13.6.B(1) Code of Ethics

As part of basic training, the provider shall distribute to all personal care aides a code of ethics. The code of ethics shall forbid, at a minimum, the following actions:

- Using the participant's car;
- Consuming the participant's food or drink (except water);
- Using the participant's telephone for personal calls;
- Discussing own or others' personal problems or religious or political beliefs with the participant;
- Accepting gifts or tips;
- Bringing other persons to the participant's home;
- Consuming alcoholic beverages, or using medicine or drugs for any purpose, other than medical, in the participant's home or prior to service delivery;
- Smoking in the participant's home;
- Soliciting or accepting money or goods for personal gain from the participant;

- Breaching the participant's privacy and confidentiality of information and records;
- Purchasing any item from the participant even at fair market value;
- Assuming control of the financial and/or personal affairs of the participant or of his/her estate including power of attorney, conservatorship, or guardianship;
- Residing with the participant in either the participant's or personal care aide's residence;
- Taking anything from the participant or from the participant's home; and
- Committing any act of abuse, neglect, or exploitation.

13.6.B(2) Training Contents

Basic training for all personal care aides shall include at least the following:

- Organization, purpose and philosophy of the personal care provider;
- Relationship of the provider to the appropriate state agency, or its designee, and MO HealthNet Division;
- Code of ethics;
- Activities which shall and shall *not* be performed under the standards for personal care services;
- Basic first aid and procedures to be followed in an emergency;
- Information about record-keeping and report forms required by the standards;
- Techniques in basic personal care activities;
- Techniques in food preparation, nutritional requirements, and basic sanitation practices;
- Household management and home maintenance skills, as they relate to personal care;
- Safety precautions and recognition of job hazards;
- Information about the availability of other community resources;
- Occupational Safety Hazards Act (OSHA) standards regarding precautions to be taken to avoid risks associated with bloodborne pathogens; and
- Review of infection control and universal precaution procedures as defined by the Centers for Disease Control.

13.6.C WAIVER OF BASIC TRAINING

13.6.C(1) Experience or Aide Certification

The provider *must* supply 8 hours of classroom training, but may waive the additional 12 hours of the personal care aide's basic training with adequate documentation in the employee's records that the employee has received similar training during the current or preceding state fiscal year, or has been employed as an aide in an in-home or home health agency at least half-time for six months or more within the current or preceding state fiscal year. The eight hours of classroom training *must* include two hours of provider agency orientation.

13.6.C(2) Licensed Nurse/Certified Nurse Assistant (CNA)

All basic training requirements, except a minimum two hour provider agency orientation may be waived, with documentation in the aide's personnel record that the aide is a registered nurse, licensed practical nurse or certified nurse assistant.

13.6.C(3) Provider Verification

It is ultimately the provider's responsibility to judge whether or not the previous training was sufficient to justify a waiver. If the training is waived, the provider should obtain adequate documentation about the employee's previous training. The provider may obtain written or phone verification of the previous training which includes at least the following:

1. The name, address, and phone number of the employer from whom the training was received.
2. The date or dates of the training.
3. A summary of the content and number of hours of the training.
4. For phone verification, the date of the phone contact, and the name of the person verifying the training information.

13.6.D SUPERVISED ON THE JOB TRAINING REVIEW

The on the job training review shall consist of the observation of the aide's performance of hands-on personal care tasks under the direction of a designated trainer. The designated trainer(s) may be the RN, LPN, supervisor or an experienced aide who has been employed by the provider agency at least six (6) months. This review may take place during an on-site visit to a participant or in a classroom demonstration and *must* be performed within 30 days of the first date of employment.

The supervised on the job training review should include observed demonstration of personal care tasks such as:

- Making beds and changing sheets with the participant in the bed;
- Brushing, combing, and shampooing hair;
- Giving bed baths and assisting with other baths;
- Giving assistance to and from the bed to a wheelchair, walker or chair when a participant is weight bearing;
- Cleaning and cutting fingernails and toenails of participants without contraindicating conditions;
- Applying non-prescription topical ointments/lotions to unbroken skin at the participant's direction.

The designated trainer must document that the aide can successfully perform demonstrated tasks. This documentation must be filed in the aide's personnel record.

13.6.E IN-SERVICE TRAINING

All personal care aides shall receive a total of ten (10) hours of in-service training annually after the first 12 months of employment.

At least six (6) hours of the required ten (10) hours shall be classroom instruction. The additional four (4) hours may use any appropriate training method. A training hour is 60 minutes.

The provider may waive the required annual in-service training hours, and require only two (2) hours of refresher training annually, when the aide has been employed for three (3) years and has completed 30 hours of in-service training that meets the standards set forth in this section. This waiver shall be adequately documented and noted in the personal care aide's records.

Training should be conducted by the provider staff, as well as, by professionals available from other agencies such as the University Extension Service, County Health Departments, Red Cross, or other community resources. Training shall reinforce and extend the content of basic training. Training should include topics such as:

- Processes and effects of aging;
- Problem identification and procedures for making appropriate referrals;
- Non-medical personal care of the incapacitated participant;
- Techniques for assisting the participant with impaired mobility;
- Meal preparation for special diets;
- Home management and budgeting;
- Comparison shopping techniques;

- Problems common to the elderly and disabled;
- Recognizing and reporting abuse or neglect;
- AIDS education;
- Alzheimer's and related dementia; and
- Death and dying.

13.7 RECORDS

The personal care provider shall document implementation of requirements for the following, as applicable:

- Coordination with other providers;
- Non-discrimination on basis of disabilities; and
- Administrative policies and procedures.

13.7.A PARTICIPANT CASE RECORD

The provider shall maintain a participant case record including records of service provision for each participant. The participant record is confidential and shall be protected from damage, theft, and unauthorized inspection. It shall be maintained in a central location, and shall contain at least the following:

- The Authorization for Services form and the Service Authorization Supplement Form, which documents authorization for all units of service provided;
- The participant's service log sheets, which *must* contain the personal care aide's name, the participant's name, dates of service delivery, time spent and activities performed on each date, and the participant's signature for each date of service. If the participant cannot write, his or her mark (X) shall be witnessed by at least one person who may be the personal care aide. Another responsible person, present in the home while the service is delivered, may sign the service log for each date of service;
- Each provider may design its own service log sheet, but all paid units of service *must* be documented. If these documents are *not* maintained in the participant's case record, they *must* be maintained in an area that is readily available for monitoring or inspection by the Departments of Social Services and Health and Senior Services;
- Documentation of undelivered services;
- Residential Care Facilities (RCF) and Assisted Living Facilities (ALF) must maintain documentation which must contain the personal care aide's name, the

participant's name, dates of service delivery, and activities performed on each date, and the participant's' signature for each date of service. All paid units of service must be documented. Reference section 13.7.D(1) of this manual and 13 CSR 70-91.010(4)(A)2.A-F for additional documentation requirements. If these documents are not maintained in the participant's case record, they must be maintained in an area that is readily available for monitoring or inspection by the Departments of Social Services and Health and Senior Services;

- The RN's written notes concerning any on-site visits made to the participant. Refer to Section 13.5.A;
- Documentation of all correspondence and contacts with the participant's physician or other care providers;
- Any other pertinent documentation regarding the participant. Refer to Sections 13.8.D and 13.9.G(2); and
- Documentation that prior to initiation of service the participant was informed of their rights under the Advanced Health Care Directive. Documentation should include whether an Advanced Health Care Directive was executed by the participant. For more information concerning Advanced Health Care Directive, please reference Section 21.

13.7.B PERSONNEL RECORD

The provider *must* maintain an individual record for each personal care aide. A personnel record is a confidential record and shall be protected from damage, theft and/or unauthorized inspection. An individual personnel record shall include, at a minimum, the following:

- Employment application with the personal care aide's signature showing, education and work experience;
- The aide's date of birth, date of employment and the date the provider terminated the aide (if applicable) must be documented in the personnel file by the provider;
- For supervisory staff, documentation that they have been provided with and have read Section 13.3.A of this provider manual;
- Documentation of at least 2 references contacted;
- Documentation of basic and in-service training received (individual training report; reference Section 13.6.A);
- Documentation of any waiver or reduction of employment or training requirements (reference Section 13.6.C);

- Annual performance evaluation which includes observations from at least one on-site visit (reference Section 13.4);
- Signed statement(s) verifying that the personal care aide received a copy of the participant's rights and the code of ethics, and that the provider's policy regarding confidentiality of participant information was explained prior to service delivery;
- Statement identifying the personal care aide's position, including whether the employee performs administrative duties for the provider or delivers services to participants; and
- Returned I.D. card for a terminated personal care aide, or documentation of why it is *not* available.

The provider *must* also maintain the written plans for basic and in-service training (Section 13.6), and the supervisor's and the RN's on-site visiting log (Section 13.4.A).

13.7.C RETENTION OF RECORDS

MO HealthNet providers *must* retain for 5 years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the MO HealthNet Agency, and *must* furnish or make the records available for inspection or audit by the Departments of Social Services and Health and Senior Services or their representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to the MO HealthNet Program may result in recovery of the payments for those services *not* adequately documented and may result in sanctions to the provider's participation in the MO HealthNet Program. This policy continues to apply in the event of the provider's discontinuance as an actively participating MO HealthNet provider through change of ownership or any other circumstance. The provider *must* make records available for unannounced inspections and audits, with access during normal business hours by the Departments of Social Services and Health and Senior Services or the U.S. Department of Health and Human Services.

13.7.D ADEQUATE DOCUMENTATION

All services provided *must* be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3 defines "adequate documentation" and "adequate medical records" as follows:

Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnoses, treatments, prognosis and the identity of the patient to

which these things relate can be readily discerned and verified with reasonable certainty. All documentation *must* be made available at the same site at which the service was rendered.

13.7.D(1) Required Documentation

The following are the requirements for the documentation of services rendered.

1. The date of the service.
2. The time spent providing the service. Time spent *must* be documented by one of the following methods:
    - Actual clock time of the start and actual clock time of the end of any period of uninterrupted one-on-one service to a single individual is documented. For example, if a personal care aide is providing services to one individual in a private home setting and devotes undivided attention to the care required by that individual, the actual clock time the aide began the services for that visit is the start time, and the actual clock time the aide finished the care for the visit is the stop time. (Example—Time spent: 9:30 a.m. to 10:30 a.m.) IF more than one visit per day is required, each separate visit has a start and a stop clock time noted. This method may also be used in a setting where the aide is providing care to and dividing his or her attention among several individuals. The actual clock start and stop time for each period of uninterrupted service for each individual is clearly documented.
    - Pursuant to RSMo 660.023, all in-home services provider agencies shall by July 1, 2015, have, maintain, and use a telephone tracking system for the purpose of reporting and verifying the delivery of home and community-based services as authorized by the Department of Health and Senior Services. At a minimum, the telephone tracking system shall: record the exact date services are delivered; record the exact time the services begin and exact time the services end; verify the telephone number from which the services were registered; verify the number from which the call is placed is a telephone number unique to the client; require a personal identification number unique to each personal care attendant; and be capable of producing reports of services delivered, tasks performed, client identity, beginning and ending times of services and date of service in summary fashion that constitute adequate documentation of service. Telephony approval may be obtained by the provider submitting a written request to Missouri Medicaid Audit and

Compliance Unit (MMAC), PO Box 6500, Jefferson City, MO 65402. The request must include the name of the company that will be used to provide the telephony service and the expected start date. Final approval to participate will require the provider to enter an addendum to their current participation agreement with MMAC.

- When the personal care services are provided in congregate living settings, such as a Residential Care Facility (RCF) or Assisted Living Facility (ALF), personal care aide staff will divide their time among a number of individuals, the following must be documented: all tasks performed for each participant by date of service and by staff shifts during each 24 hour period.
- Any other method that includes all required elements of documentation listed in this section.

3. A description of the service (specific tasks).
4. The name of the personal care aide who provided the service.
5. The participant's name and MO HealthNet number.
6. For each date of service: the signature of the participant, or the mark of the participant witnessed by at least one person, or the signature of another responsible person present in the participant's home or licensed Residential Care Facility (RCF) or Assisted Living Facility (ALF) at the time of service. A responsible person may include the personal care aide's supervisor, if the supervisor is present in the home or licensed RCF or ALF at the time of service delivery. The personal care aide may only sign on behalf of the participant when the participant is unable to sign and there is no other responsible person present. The entire signature of the participant or witness to the mark or the responsible party *must* be present in the record for each date of service billed to MO HealthNet. Initials are *not* acceptable in lieu of the entire signature.

The provider shall *not* submit claims solely on the basis of the prior authorization, but *must* base claims upon documentation of actual services rendered. The participant may have been in the hospital or nursing facility during a month, may have been away from the home visiting family or friends, or there may have been other reasons why all services which were prior authorized were *not* necessary or could *not* be delivered. The prior authorization merely establishes the maximum number of units and types of services which may be given to a participant during a time period. All units billed to MO HealthNet *must* be supported by the documentation of delivery as described in this section.

DHSS assumes a 31-day month in calculating the monthly maximum number of personal care units for which each participant is eligible. However, several plans of care assign tasks to be performed seven times per week (daily); and, several months in the year contain fewer than 31 days. For RCF and ALF personal care providers, when a participant's plan of care includes at least one task that is to be performed daily, then the participant's monthly maximum allotment cannot be reached in a month containing fewer than 31 days. When determining compliance with this limitation, the following steps may be used to manually calculate the monthly authorization:

NOTE: This only pertains to RCF and ALF Personal Care providers.

Step 1: Identify the daily tasks (tasks shown on the care plan as daily or with a frequency of 7 times a week).

Step 2: Identify the total number of minutes for these daily tasks in a week (this may appear directly on the care plan, or determined by multiplying the total number of daily task minutes by 7).

Step 3: Divide the number in step 2 by 15. Round up to the nearest whole number (.5 or more rounds up). This will equal the daily task units per week.

Step 4: Divide the number in step 3 by 7. Round up to the nearest whole number (.5 or more rounds up). This will equal the daily task units per day.

Step 5: Multiply the number in step 4 by the number of days fewer than 31 in the month. (Take the number from step 4 and multiply it by 1 for April, June, September, and November. Multiply it by 3 for February. Multiply it by 2 for February in a leap year.)

Step 6: Take the total from step 5 and subtract it from the total number of authorized units. This will equal the new total of authorized units for the shorter month.

13.7.D(2) Unit of Service

A unit of personal care service is 15 minutes of direct service to the participant, including time spent completing work vouchers and obtaining participant signatures. Time spent for travel, lunch, breaks, or administrative activities such as completing other reports or paperwork shall *not* be included.

13.7.D(3) Accrued Units

Personal care providers may bill up to one full month of service on one detail line of a claim. It is permissible to accrue partial units of less than 15 minutes for

several dates of service and bill the total, in whole units (15 minutes), at the end of the day, week, or month, as long as care delivery is consistent with the written plan of care.

The following instructions apply to billing accrued units on separate detail lines of a claim:

- When billing each date of service, partial units may be accrued and billed on the first date a *whole unit* is accrued. For example, a provider delivers care from 10:00 AM to 11:40 AM on June 1, then provides care from 10:00 AM to 12:10 PM on June 4. Six units of service are billed for June 1, and 9 units of service are billed on June 4.
- When billing multiple dates of service on one detail line of a claim, total the time spent in minutes for each date, divide by 15, and bill the number of whole units. Do *not* round up to the nearest whole unit. For example, at the end of the month, time spent in the provision of personal care to an individual in a congregate living facility, who received services every day, totals 620 minutes. 620/15=41.33 units. Bill for 41 whole units of service.
- When billing multiple dates of service on one detail line of a claim, dates during which the client is in a hospital, in a nursing home facility, visiting relatives or is ineligible should *not* be included in the range of dates.
- When billing multiple dates of service on one detail line of a claim, do *not* bill for dates of service falling in two separate calendar months.

13.8 THE AUTHORIZED NURSE VISIT

The authorized nurse visit is a covered service under the MO HealthNet Personal Care Program. Reimbursement is made for supervision of the Personal Care Program, in addition to the visits by a nurse to particular participants with special needs, when such visits are prior authorized by the Department of Health and Senior Services' Division of Senior and Disability Services or its designee, or Bureau of Special Health Care Needs.

Providers of personal care services *must* have the capacity to provide these authorized nurse visits as well as the non-authorized nurse supervision requirements outlined in the Personal Care Program standards.

The nursing services that may be authorized in the participant's home are services of a maintenance or preventative nature provided to participants with stable, chronic conditions. These services are *not* intended as treatment for an acute health condition and may *not* include services that are reimbursable as skilled nursing care under either the Medicare or MO HealthNet Home Health Programs. Should the provider nurse detect a need for services that meet the definition of reimbursable skilled nursing care under the Home Health Program, the provider nurse *must* alert the

participant's physician and the appropriate state agency or its designee. The physician may then refer the participant to a home health agency for treatment.

13.8.A PARTICIPANT ELIGIBILITY

To be eligible for the authorized nurse visit, the participant *must* receive a personal care service and have a documented need for the authorized nurse visit and have no adequate support system that could provide these services to the participant.

Authorized nurse visits are limited to 26 within a 6-month time frame.

13.8.B SERVICES WHICH MAY BE AUTHORIZED

The services of the nurse shall provide increased supervision to the personal care aide and maintenance or preventative services, assessment of the participant's health and the suitability of the service plan to meet the participant's needs. All advanced personal care participants *must* have at least one authorized nurse visit per month. These services shall also include any referrals or follow-up action indicated by the nurse's assessment. In addition, these services *must* include one or more of the following where appropriate to the needs of the participant and authorized by the appropriate state agency:

- Filling a one-week supply of insulin syringes for a diabetic who can self-inject the medication but *cannot* fill his own syringe. This service includes monitoring the participant's continued ability to self-administer the insulin. If the participant is otherwise eligible for services reimbursed through the Home Health Program, the authorized nurse visit through the Personal Care Program to pre-fill the syringes is *not* appropriate, since the service could and would be provided by the home health nurse;

  NOTE: Manufacturers recommend that certain insulin should not be pre-filled into syringes.

- Setting up oral medications in divided daily compartments for a participant who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;
- Monitoring a participant's skin condition when a participant is at risk of skin breakdown;
- Conducting health evaluations;
- Providing nail care for the diabetic participant with other medically contraindicating conditions who is unable to perform this task, such as:
  - Circulatory or neurologic deficiency;
  - Taking anticoagulant medications, such a Coumadin;
  - Diagnosed with peripheral vascular disease; or

- Diagnosed with compromised immune system, i.e., HIV and chemotherapy.

- Making a monthly on-site visit to each participant for whom advanced personal care services are authorized to evaluate the condition of the participant. A monthly visit report is documented through a provider general health evaluation and level of care recommendation form. This document must be maintained in the participants file. If critical issues are found during this on-site visit, the HCBS Regional Evaluation (REV) Team must be contacted immediately. The Semi-annual General Health Assessment form *must be* forwarded to the appropriate HCBS REV Team after completion. If critical issues are found during the semi-annual General Health Assessment the HCBS REV Team *must* be contacted immediately;
- Providing on-the-job training and competency testing for advanced personal care aides.

The state agency or its designee, at their discretion, may recommend authorization of nurse visits in other situations.

The authorized nurse visits listed above may be provided by an LPN, if under the direction of an RN or physician, except an RN *must* perform the on-the-job training and competency testing for advanced personal care aides. The services provided during the authorized nurse visit shall *not* include any service which the participant is eligible to receive under either the Medicare (Title XVIII) or MO HealthNet (Title XIX) Home Health Programs. The services listed above do *not* qualify, by themselves, for reimbursement under either program. However, should a participant otherwise be eligible for home health services, then the following services: filling a one week supply of insulin syringes, setting up oral medications in divided daily compartments, monitoring a participant's skin condition when the participant is at risk of skin breakdown and nail care for a diabetic or a participant with other medically contraindicating conditions, will be provided by the home health agency.

It is the responsibility of the nurse to contact the participant's physician to obtain any necessary information or orders pertaining to the care of the participant. If the participant has an ongoing need for service activities that require more or less units than authorized, the nurse shall recommend in writing, that the plan of care be revised.

13.8.C AUTHORIZED NURSE ADMINISTRATIVE REQUIREMENTS

The following administrative requirements must be maintained whenever the authorized nurse services are delivered. These requirements are in addition to the administrative standards of the Personal Care Program outlined in Section 13.2.

The provider shall provide a general orientation for the nurse prior to the delivery of services which shall include instruction on the following:

- Code of ethics;

- Participant's bill of rights;
- Activities which shall or shall not be performed;
- Infection control and universal precaution procedures as defined by the Centers for Disease Control;
- Record keeping requirements and reporting forms required by the personal care provider or state agency, or its designee who authorized the service;
- Occupational Safety Hazards Administration standards regarding precautions to be taken to avoid risks associated with bloodborne pathogens; and
- Communicating with the appropriate state agency or its designee and taking appropriate action on clinical changes in the participant's condition.

13.8.D AUTHORIZED NURSE VISIT RECORDS

Written notes concerning the authorized nurse's visits must be maintained in the participant's file. In addition, notes of any verbal communication and copies of any written communications with the participant's physician, other health care professional, or state agency, or its designee, concerning the care of that participant, is also maintained in the participant's file.

13.9 ADVANCED PERSONAL CARE SERVICES

The provision of advanced personal care services is an option available to providers under the MO HealthNet Personal Care Program. These advanced personal care tasks are maintenance services provided to assist a participant with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body functions.

Advanced personal care is a maintenance service and should never be used as a therapeutic treatment. Participants who develop medical complications requiring skilled nursing services while receiving advanced personal care services shall be referred to their attending physician who may, if appropriate, order home health services, inpatient care, or institutionalization.

All personal care standards set forth in Section 13 also apply to the Advanced Personal Care Program unless specifically stated otherwise. The requirements contained in this section are in addition to the Personal Care Program standards and pertain only to the delivery of advanced personal care services.

13.9.A SERVICE DESCRIPTION

Examples of advanced personal care services that may be performed are:

- Routine personal care for persons with ostomies (including tracheostomies, gastrostomies and colostomies with well-healed stoma) and external, indwelling, and suprapubic catheters. This care includes changing bags, and soap and water hygiene around ostomy or catheter site;

- Remove external catheters; inspect skin and reapplication of same;
- Administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (pre-packaged only) for participants without contraindicating rectal or intestinal conditions;
- Apply medicated (prescription) lotions or ointments, and dry, non-sterile dressing to unbroken skin;
- Use lift, or other device, for transfers;
- Manually assist with oral medications which are set up by a registered or licensed practical nurse;
- Provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology; and
- Apply non-sterile dressings to superficial skin breaks or abrasions as directed by a registered or licensed practical nurse.

Personal care providers choosing to offer advanced personal care are required to provide all of the above listed services.

13.9.B PROVIDER PARTICIPATION REQUIREMENTS

Providers choosing to deliver advanced personal care services must have a valid MO HealthNet Personal Care Provider Agreement in effect with the Missouri Medicaid Audit and Compliance Unit (Section 13.1.D). In addition, the provider must sign an addendum to their Title XIX Personal Care Provider Agreement, indicating their agreement to provide advanced personal care services.

Only those personal care providers meeting one of the following requirements may sign the addendum; and subsequently, be authorized to provide advanced personal care:

A. Title XX (Social Service Block Grant) providers whose contract includes advanced personal care.

B. A Residential Care Facility (RCF) or Assisted Living Facility (ALF) licensed by the Division of Regulation and Licensure.

Upon approval of the advanced personal care provider application, RCF/ALF advanced personal care providers may only furnish advanced personal care services to participants in their RCF/ALF. If an RCF/ALF provider wants to provide advanced personal care services in the community it must submit a proposal to Missouri Medicaid Audit and Compliance Unit (MMAC) PO Box 6500, Jefferson City, MO 65102-6500, and *must* receive approval as a Title XX (Social Service Block Grant (SSBG)) provider before services can be approved.

Providers may contact MMAC at (573) 751-3399 for information regarding the SSBG provider program.

The addendum and verification of the Title XX contract should be submitted to the MMAC, Provider Enrollment Unit, PO Box 6500, Jefferson City, Missouri 65102-6500. Click here for a copy of the MO HealthNet Advanced Personal Care Program Addendum to Title XIX Participation Agreement for Personal Care Services.

13.9.C PARTICIPANTS MINIMUM NEEDS CRITERIA

In addition to meeting the eligibility requirements of the Personal Care Program (Section 13.1.E), the participant *must* have a documented need for the advanced personal care service(s) and have no adequate support system that could provide these services to the participant. The participant *must* have a qualifying altered body function, etc. as described in Section 13.9. Participants are assessed as eligible for personal care or advanced personal care by one of the appropriate state agencies, the Department of Health and Senior Services, Division of Senior and Disability Services or its designee, the Division of Community and Public Health (DCPH), Bureau of HIV, STD, and Hepatitis, and Bureau of Special Health Care Needs (BSHCN). (For children and for persons with AIDS/HIV, see Section 13.15.G and Section 13.16.)

13.9.D AUTHORIZATION OF ADVANCED PERSONAL CARE

All units of advanced personal care *must* be authorized by the state agency or its designee before services can be delivered. The plan of care *must* be developed, reviewed, and updated by the provider's RN in cooperation with state agency or its designee. For advanced personal care services authorized by BSHCN for children (age 0-20 yr. old), the advanced personal care plan must be updated every six months.

13.9.E ADVANCED PERSONAL CARE RN SUPERVISION

RN supervision is essential to the safe provision of advanced personal care services. Certain nurse functions for advanced personal care participants may be performed by a licensed practical nurse; others *must* be performed by a registered nurse. The following outlines the nursing requirements for advanced personal care participants:

The registered nurse *must*:

- conduct an initial assessment visit and develop the plan of care for participants with advanced personal care needs, in collaboration with the state agency staff or its designee. The provider may request a change in the care plan if determined through this initial assessment. This request should be made to the appropriate Department of Health and Senior Services (DHSS) staff. This visit may be authorized and billed to MO HealthNet as an authorized nurse visit.

- conduct on-site visits to all advanced personal care participants at intervals no greater than six months. During the visit, the RN *must* conduct and contemporaneously record and certify by his/her signature an individualized evaluation of the participant's condition, the adequacy of the authorized services to meet the needs and conditions of the participant, including a review of the care plan with the participant.
- be available, at least by telephone, during any period of time advanced personal care is being provided.
- observe the successful execution by the aide of each advanced personal care task during an on-the-job training session, and certify the successful completion of the task in the aide's personnel record. This visit may be authorized and reimbursed.

The licensed practical nurse may, under the direction of a registered nurse:

- conduct the monthly authorized nurse visit to evaluate the condition of the advanced personal care participant and the adequacy of the care plan to meet the needs and conditions of the participant, including a review of the care plan with the participant.

13.9.F ADVANCED PERSONAL CARE AIDE REQUIREMENTS

In addition to meeting the basic personal care aide requirements discussed in Section 13.3.B of this manual, all advanced personal care aides employed by the provider *must*:

- be an LPN or a certified nurse assistant; or
- be a competency evaluated home health aide having completed both written demonstration portions of the test required by the Missouri Department of Health and Senior Services and 42 CFR 484.36.; or• have successfully worked for the provider for a minimum of three consecutive months while working at least fifteen hours per week as an in-home aide that has received personal care training.

13.9.G ADVANCED PERSONAL CARE AIDE TRAINING

Advanced personal care aides *must* receive eight classroom hours of advanced personal care training in addition to the required basic training for personal care aides as described in this manual. The provider shall have written plans of the classroom training; such training *must* include at a minimum the following topics:

- observation of the participant and reporting observations;
- application of ointments/lotions to broken skin;
- manual assistance with oral medications;
- prevention of decubiti;
- enemas;
- basic personal care for persons with ostomies and catheters;

- proper cleaning of catheter bags;
- bowel routines (rectal suppositories, sphincter stimulation);
- passive range of motion exercises;
- use of assistive device (i.e., lifts, transfer boards, etc.) for transfers;
- positioning and support of the participant;
- applying non-sterile dressings to superficial skin breaks; and
- universal precaution procedures as defined by the Centers for Disease Control.

The provider *must* document the dates and hours of the eight classroom hours of advanced personal care training received by the personal care aide in the aide's personnel file.

13.9.G(1) Waiver of Classroom Hours

The provider may waive the eight classroom hours of advanced personal care training if the following conditions are met:

- the advanced personal care aide is a certified nurse assistant or a licensed practical nurse currently licensed or registered in the state of Missouri; or
- the personal care aide has previously completed advanced personal care training from a Missouri Medicaid in home provider agency contracted with Missouri Medicaid Audit and Compliance Unit in-home provider; and
- the personal care aide has been employed at least half time by a Missouri Medicaid in-home provider *as an advanced personal care aide within the prior six (6) months*.

If the waiver of advanced personal care training has been granted, documentation that the above conditions have been met *must* be placed in the aide's personnel record and available for inspection.

13.9.G(2) Demonstration of Competency

Prior to performing any advanced personal care task for any participant for the first time, the advanced personal care aide who is *not* a licensed nurse *must* demonstrate competency, specifically for the advanced personal care tasks as they appear on a participant's plan of care. This competency *must* be demonstrated in an on-the-job training session conducted by the registered nurse. The registered nurse *must* document the aide's competency in performing each task in the aide's personnel file. The required demonstration of each advanced personal care task during an on-the-job training session with an RN may *not* be waived. RN visits necessary for task observation and certification in the home may be prior authorized and billed to

MO HealthNet as an authorized nurse visit. RN task observation and certification in a laboratory, or other non-home setting, may *not* be billed.

The RN *must* observe the aide performing the following tasks in the participant's home.

- routine personal care of persons with ostomies (including tracheostomies, gastrostomies, colostomies all with well-healed stoma) which includes changing bags, and soap and water hygiene around ostomy site;
- personal care of persons with external, indwelling, and suprapubic catheters which includes changing bags, and soap and water hygiene around site;
- removal of external catheters, inspect skin and reapply catheter;
- administration of prescribed bowel programs, including use of suppositories and sphincter stimulation per protocol and enemas (prepackaged only) for participants without contraindicating rectal or intestinal conditions;
- use of assistive device for transfers.

The RN may observe the following tasks in the home or lab setting.

- application of medicated (prescription) lotions, ointments or dry, aseptic dressings to unbroken skin including stage I decubitus;
- application of aseptic dressings to superficial skin breaks or abrasions as directed by a licensed nurse;
- manual assistance with noninjectable medications as set up by a licensed nurse;
- passive range of motion (nonresistive flexion of joint with normal range) delivered in accordance with the care plan.

13.9.G(3) Annual In-Service Training

Advanced personal care aides *must* also receive ten (10) hours of annual in-service training, the same as any personal care aide (see In-Service Training 13.6.E).

13.9.H ADVANCED PERSONAL CARE RECORDS

Providers participating in the delivery of advanced personal care services *must* maintain all records and documentation required of the MO HealthNet Personal Care Program. In addition, the following records and documentation that pertain only to the delivery of advanced personal care services *must* be maintained by participating providers.

13.9.H(1) Aide's Personnel Record

The personal care aide's personnel record shall contain:

- Documentation of the eight classroom hours of advanced personal care training including dates and topics;
- Documentation for any waiver of the eight (8) classroom hours of advanced personal care training; and
- Signed statement(s) by the RN certifying that the personal care aide has successfully completed on-the-job training for each advanced personal care task the aide is required to perform.

13.9.H(2) Participant's Record

The case record of any participant receiving advanced personal care services shall include:

- Written notes concerning any authorized nurse visits including the six month supervisory visit and the monthly nurse visit report. In addition, notes of any verbal communication and copies of any written communication with the participant's physician or other health care professional, concerning the participant's care *must* be maintained in the participant's case record.
- A closing summary documenting that 21 day notification was given to the state agency or its designee, and the advanced personal care participant prior to the date of closing, the participant's authorization date, the most recent care plan including identified functional disabilities, the reason for closing, the date of closing, and a follow-up plan, if applicable.

13.10 GENERAL INFORMATION – PERSONAL CARE ASSISTANCE – CONSUMER-DIRECTED SERVICES (CDS) OPTION

The Personal Care Assistance—Consumer-Directed Services (CDS) Personal Assistance (PCA) program is authorized by the Department of Health and Senior Services/Division of Senior and Disability Services(DHSS)/(DSDS).

13.10.A SERVICE DEFINITION

Personal Care Assistance - CDS are services that are required or may be provided as part of the CDS program.

Under CDS, the participant is responsible for hiring, training, supervising, and directing the personal care attendant.

Authorization of CDS is funded through both the Medicaid state plan and the Independent Living Waiver (ILW). This policy addresses the Medicaid state plan services only.

13.10.B PERSONAL CARE TASKS

CDS Personal Care tasks include but are not limited to:

- Bathing, including shampooing hair:
- Dressing/grooming; includes dressing/undressing, combing hair, nail care, oral hygiene and denture care, and shaving;
- Ostomy or catheter hygiene;
- Bowel and/or bladder routine;
- Assistance with toileting;
- Use of transfer devices/assistance with mobility issues/prostheses;
- Passive range of motion;
- Manual assistance with medications (i.e., prompting while assisting, opening mediplanner, handing a glass of water, steadying the glass of water);
- Turning and positioning;
- Treatments;
- Cleaning and maintenance of equipment;
- Clean bath;
- Make bed;
- Change linens;
- Clean floors;
- Tidy and dust;
- Laundry (home);
- Laundry (off-site);
- Trash;
- Read/write essential correspondence;
- Meal preparation and/or assist with eating;
- Wash dishes;
- Clean kitchen; and

- Transportation – Essential shopping/errands, school, or employment. For the participant to be eligible for transportation assistance there must also be an identified need for personal care assistance, even if that is met by supports other than CDS.

13.10.C SERVICE LIMITATIONS

- All participants must be capable of living independently (reside in a non-institutional or unsupervised residential setting) with CDS. CDS shall not be authorized to pay for services:
- When the primary benefit is to a household unit; or
- When the task is one that members of a household may reasonably be expected to share or do for one another, unless the task is above and beyond typical activities that would be provided for a household member without a disability.
- CDS provides "hands on" assistance with physical tasks that benefit the participant and are based on the physical limitations of the participant.
- No time can be allotted for stand-by assistance, prompting, or cueing;
- No time can be allotted for respite care or for time spent waiting for a participant at a physician's office, or any other appointment.
- CDS does not include any task that must be performed/trained by a licensed professional (i.e., skilled nursing, therapies ordered by a physician, etc.).
- A physically disabled participant with a *cognitive* impairment that does not affect their ability to self-direct is authorized through the Independent Living Waiver only; these participants cannot be authorized through the state plan (CDS).
- Participants authorized for any type of residential habilitation services through the Department of Mental Health (DMH) shall not be authorized CDS as outlined in this policy. The service entitled 'Individualized Supported Living' (ISL) is considered a residential habilitation service. To facilitate service coordination, the 'Medical Hx' (History) tab within CyberAccess provides a procedure link. If the participant is enrolled in CDS they cannot also be participating in DMH Division of Developmental Disabilities (DD) self-directed services.

13.10.D PROVIDER PARTICIPATION

The provider of consumer directed services must have a valid MO HealthNet Personal Care Agreement in effect with the Department of Social Services (DSS), MMAC, pursuant to federal and state laws and regulations.

13.10.E PARTICIPANT ELIGIBILITY FOR PERSONAL CARE ASSISTANCE SERVICES – CONSUMER DIRECTED MODEL

All CDS participants must meet the following eligibility criteria:

- Be at least 18 years of age;
- Be physically disabled (Loss of, or loss of use of, all or part of the neurological, muscular or skeletal functions of the body to the extent that the person requires the assistance of another person to accomplish routine tasks);
- Be able to self-direct their own services/care;
- Be capable of living independently with CDS;
- Be in active Medicaid status;
- Participants who are eligible for Medicaid on a spenddown basis may be authorized to receive CDS during periods when they meet their spenddown liability.
- A participant is responsible for the cost of services received during periods of time when they have **not** met their spenddown liability; and
- Meet nursing facility level of care.

13.10.F AUTHORIZATION OF PERSONAL CARE ASSISTANCE – CONSUMER DIRECTED SERVICES

All units of Title XIX personal care services must be authorized by a qualified state agency or its designated staff before services can be delivered.

The detailed care plan or authorization for services shows how many units of service are authorized and specifies the period of time covered by the authorization. In addition, the care plan includes a list that shows the specific service activities that must be performed, at a minimum, by the personal care attendant . Additional service activities may be performed as long as the time spent does not exceed the time (units) authorized.

More information about documentation is contained in Section 14 of this Manual.

When individuals receive both state plan personal assistance and DD waiver personal assistance, the DHSS service authorization system must coordinate closely with the local DD support coordinator.

13.11 ADMINISTRATION – PERSONAL CARE ASSISTANCE – CONSUMER DIRECTED SERVICES

The following administrative standards must be followed whenever personal care services through the Consumer Directed Services are being delivered.

Each participating provider must have a valid provider agreement in effect with the MO HealthNet Division to provide personal care services.

The provider must notify Missouri Medicaid Audit and Compliance (MMAC) at least 30 days before a change of ownership of the provider's business. The provider must notify MMAC within at least 90 days before any other changes, such as change in location, telephone number, administrative, or corporate status. Provider must notify MMAC in writing and should use the Change Request Form.

13.11.A PARTICIPATION AND NOTIFICATION REQUIREMENTS

The consumer will be responsible, at a minimum, for the following:

- Selection, hiring, training, and supervision of the personal care attendant;
- Preparation of biweekly time sheets, signed by both the participant and the attendant, which shall be submitted to the provider in a timely manner;
- Ensuring that units submitted for reimbursement do not exceed the amounts authorized by the CDS care plan and/or those eligible for reimbursement through MO HealthNet;
- Promptly notifying DSDS and/or the provider within 10 days of any changes in circumstances affecting the CDS plan of care and/or changes in the place of residence; and
- Prompt notification to the provider regarding any problems resulting from the quality of services rendered by the attendant. Any problems not resolved with assistance from the provider shall be reported to DSDS.

13.11.B PROVIDER – GENERAL ADMINISTRATIVE REQUIREMENTS

- Providers must perform, directly or by contract, payroll and fringe benefit accounting functions for participants, including but not limited to:
- Collecting timesheets and certifying their accuracy;
- Transmitting individual payments to the personal care attendant on behalf of the consumer;
- Ensuring all payroll, employment, and other taxes are filed and paid timely under the consumer's tax ID#;
- File claims for MO HealthNet reimbursement;
- Processing of consumers' and/or attendants' inquiries and problems;
- Public information, outreach and education activities to ensure that persons with disabilities are informed of the services available and have maximum opportunity for participation;

- Maintain confidentiality of consumer's records, including eligibility information from DSDS, according to federal and state laws and regulations;
- Perform case management activities with the consumer at least monthly to provide ongoing monitoring of the provisions of services in the plan of care and other services as needed to live independently;
- Ensure the consumer has an emergency and/or back up plan;
- Monitor utilization of units by the consumer at least monthly; and

Providers must maintain a list of eligible attendants:

- Ensuring that each attendant is registered, screened, and employable according to the Family Care Safety Registry (FCSR), the Office of Inspector General (OIG) and the Employee Disqualification List (EDL) maintained by DHSS, and applicable state laws and regulations; and
- Notifying the attendant of his or her responsibility to comply with applicable state laws and regulations regarding reports of abuse or neglect.

13.11.C PROVIDER SERVICE DELIVERY STANDARDS

All providers of the consumer-directed services (CDS) must have a philosophy that promotes the participant's ability to live independently in the most integrated setting. This philosophy includes the following independent living services:

- Advocacy;
- Independent living skills training;
- Peer counseling; and
- Information and referral.

Providers must operate programs, services, and/or activities in such a manner as to be readily accessible to and usable by persons with disabilities. Providers must demonstrate a positive impact on participant outcomes, regarding the provision of CDS through the submission of quarterly service reports and an annual service report to MMAC.

Necessary information must be provided to conduct state and/or federal audits, as requested by DHSS and/or MMAC. Providers must comply with the applicable statutes and regulations regarding reports of abuse or neglect. Providers are responsible to comply with applicable statutes and regulations regarding reports of misappropriation of a consumers' property or funds or the falsification of documents verifying CDS delivery.

13.11.C(1) Participant Nonliability

MO HealthNet covered services rendered to an eligible beneficiary are not billable to the beneficiary if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

For questions regarding the Personal Care Program, call the Provider Relations Communication Unit's number (573) 751-2896.

13.11.C(2) Participant Cost Sharing and Copay

Consumers eligible to receive certain MO HealthNet services are required to pay a small portion of the cost of the services. Services of the CDS Program described in this manual are *not* subject to a cost sharing or copay amount.

13.11.D DISCHARGE POLICIES AND PROCEDURES

Providers should refer situations that may require closure or termination of services to DSDS or its designee for investigation. Situations to be referred include but are not limited to:

- Death;
- Admission into a long-term care facility;
- The consumer no longer needs services;
- The inability of the consumer to self-direct; and/or
- The inability to continue to meet the maintenance needs of the consumer because the plan of care hours needed to ensure the health and safety of the consumer exceed availability.

After notice to DSDS or its designee, providers may suspend services to consumers in the following circumstances:

- The inability of the participant to self-direct;
- Falsification of records or fraud;
- Persistent actions by the consumer of noncompliance with the care plan;
- The consumer or a member of the consumer's household threatens or abuses the attendant and/or provider; and/or
- The attendant is not providing the services outlined in the care plan and attempts to remedy the situation have been unsuccessful.

When suspending services, the consumer and DSDS or its designee must be notified in writing the specific reasons for requesting the closure or termination. All supporting

documentation must be maintained in the consumer's case file. DSDS or its designee investigates the circumstances reported by the provider and assists the consumer in accessing appropriate care. If the investigation concludes that any of the above circumstances exist, DSDS or its designee may close or terminate services.

13.11.E NONDISCRIMINATION

Providers must comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable Federal and State Laws that prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs. Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability, and religious beliefs.

13.11.F PROVIDER COMPLIANCE

The Departments of Social Services and Health and Senior Services or their designee conduct both program and fiscal monitoring of the CDS Personal Care Program. Monitoring visits may be announced or unannounced. The providers must agree to comply with any reviews conducted by the Departments of Social Services and Health and Senior Services or their designee. DSDS may, in accordance with the protective service mandate (Chapter 660, RSMo), take action to protect participants from providers who are found to be out of compliance with statutory and regulatory requirements applicable to the CDS Personal Care Program, when such noncompliance is determined by DSDS to create a risk of injury or harm to participants.

13.12 PERSONNEL – CDS

13.12.A PERSONAL CARE AIDE REQUIREMENTS

Attendants must meet the following qualifications:

- Be at least eighteen (18) years of age;
- Be able to meet the physical and mental demands required to perform specific tasks required by a particular consumer;
- Agree to maintain confidentiality;
- Be emotionally mature and dependable;
- Be able to handle emergency type situations; and
- Not be the consumer's spouse.

The attendant is an employee of the consumer only for the time period subsidized with CDS funds, but is never the employee of the provider, DHSS, or the state of Missouri.

13.13 TRAINING – CDS

13.13.A DOCUMENTATION OF BASIC TRAINING

Documentation must be kept in the consumer's file regarding training provided to the consumer in the skills needed to understand and perform the essential functions of an employer.

13.13.B BASIC TRAINING

Training and orientation of consumers in the skills needed to recruit, employ, instruct, supervise, and maintain the services of attendants include, but are not limited to:

- Assisting consumers in the general orientation of attendants as requested by the consumer;
- Preparation of time sheets;
- Identification of issues that would be considered fraud of the program;
- Allowable and non-allowable tasks;
- Rights and responsibilities of the attendant; and
- Identification of abuse, neglect, and/or exploitation.

13.14 RECORDS – CDS

13.14.A PARTICIPANT CASE RECORD

Participant case files must contain at a minimum the following:

- Written care plan and service authorization that document the type of services and quantity of units to be provided;
- Participant's original time sheets that contain the following:
  - Attendant's name;
  - Consumer's name;
  - Dates and times of services delivery;
  - Types of activities performed at each visit;
  - Attendant's signature for each visit; and
  - Consumer's signature verifying service delivery for each visit.

- Copies of all correspondence with DSDS, the consumers' physician, other service providers, and other administrative agencies;
- Documentation of training provided to the consumer in the skills needed to understand and perform the essential functions of an employer;
- Documentation of the consumer's emergency and/or backup plans;
- Signed documentation that the consumer has been informed of their rights concerning hearings and consumer responsibility; and
- Any pertinent documentation regarding the consumer.

13.14.B RETENTION OF RECORDS

The vendor must maintain, at a minimum, all case files and records, either electronically or in paper form, of its activities applicable to state laws and regulations in a central location for six (6) years. Records must be provided to MMAC, DHSS or its designee upon request and must be maintained in a manner that will ensure they are readily available for monitoring or inspection. Such records must include, but not be limited to, records verifying the delivery of services.

13.14.C ADEQUATE DOCUMENTATION

All services provided must be adequately documented in the medical record. The Code of State Regulations, 13 CSR 70-3 defines "adequate documentation" and "adequate medical records" as follows:

Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

13.14.C.(1) Required Documentation

The following are the requirements for the documentation of services rendered (time sheets):

1. The date of the service;
2. The time spent providing the service. Time spent must be documented by one of the following methods:

• Actual clock time of the start and end of any period of uninterrupted one-on-one service to a single individual is documented. For example, if a personal care aide is providing services to one individual in a private home setting and devotes undivided attention to the care required by that individual, the actual clock time the aide began the services for that visit is the start time, and the actual clock time the aide finished the care for the visit is the stop time. (Example—Time spent: 9:30 a.m. to 10:30 a.m.) If more than one visit per day is required, each separate visit has a start and a stop clock time noted. This method may also be used in a setting where the aide is providing care to and dividing his or her attention among several individuals. The actual clock start and stop time for each period of uninterrupted service for each individual is clearly documented.

• Pursuant to RSMo 660.023, all in-home services provider agencies shall by July 1, 2015, have, maintain, and use a telephone tracking system for the purpose of reporting and verifying the delivery of home and community-based services as authorized by the Department of Health and Senior Services. At a minimum, the telephone tracking system shall: record the exact date services are delivered; record the exact time the services begin and exact time the services end; verify the telephone number from which the services were registered; verify the number from which the call is placed is a telephone number unique to the client; require a personal identification number unique to each personal care attendant; and be capable of producing reports of services delivered, tasks performed, client identity, beginning and ending times of services and date of service in summary fashion that constitute adequate documentation of service. Telephony approval may be obtained by the provider submitting a written request to Missouri Medicaid Audit and Compliance Unit (MMAC), PO Box 6500, Jefferson City, MO 65402. The request must include the name of the company that will be used to provide the telephony service and the expected start date. Final approval to participate will require the provider to enter an addendum to their current participation agreement with MMAC.

• Any other method that includes all required elements of documentation listed in this section;

3. A description of the service (specific tasks) performed at each visit;

4. The name of the personal care attendant who provided the service;

5. The consumer's name;

6. Attendant's signature for each visit; and

7. Consumer's signature verifying service delivery for each visit.

The provider shall not submit claims solely on the basis of the prior authorization, but must base claims upon documentation of actual services rendered. The participant may have been in the hospital or nursing facility during a month, may have been away from the home visiting family or friends, or there may have been other reasons why all services which were prior authorized were not necessary or could not be delivered. The prior authorization merely establishes the maximum number of units and types of services which may be given to a participant during a time period. All units billed to MO HealthNet must be supported by the documentation of delivery as described in this section.

13.14.C.(2) Unit of Service

A unit of Personal Care Assistance – CDS is 15 minutes of direct service to the participant, including time spent completing work vouchers and obtaining participant signatures. Time spent for travel, lunch, breaks, or administrative activities such as completing other reports or paperwork shall not be included.

13.14.C.(3) Accrued Units

Personal care providers may not bill for more than one date of service per detail line. The following instructions apply to billing accrued units on separate detail lines of a claim:

- When billing each date of service, partial units may be accrued and billed on the first date a *whole unit* is accrued. For example, a provider delivers care from 10:00 AM to 11:40 AM on June 1, then provides care from 10:00 AM to 12:10 PM on June 4. Six units of service are billed for June 1, and 9 units of service are billed on June 4. Units of the same type of services may accrue, but units of different types of services may not be combined.

13.15 PERSONAL CARE SERVICES FOR CHILDREN THROUGH THE HEALTHY CHILDREN AND YOUTH PROGRAM

The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) mandated expanded services to children through the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT). In summary, OBRA '89 requires states to provide medically necessary treatment for children for conditions or problems identified through the EPSDT health screen, even if the needed medical service is beyond the scope of the state's MO HealthNet state plan. While personal care is a service under the State Plan in Missouri, historically the service has been utilized by few children. Children

with serious home care medical needs were served through the Children's Waiver prior to OBRA '89, which included private duty nursing, home health, therapy, supplies, and aide service.

Missouri implemented the mandates of OBRA '89 through the Healthy Children and Youth (HCY) Program. Many of the services now available to children under the HCY Program are prior authorized by the Bureau of Special Health Care Needs of the Department of Health and Senior Services.

13.15.A SERVICE AUTHORIZATION

Personal care services for MO HealthNet eligible children (aged 20 and under) may be authorized by the Bureau of Special Health Care Needs. There are major differences in services for children and services for adults. In cases of personal care for a child, the provider agency may receive a referral directly from a family, hospital, physician, or other referral source. The provider may then request approval for prior authorization from the Bureau. This is different from personal care for an adult.

Children are determined to be in need of personal care by medical necessity, rather than by being assessed to have nursing home level of care needs. An example of a personal care need for a child is one who needs total personal care, or requires extra assistance in bathing, toileting, eating, or other activities of daily living, because of a medical condition. The fact that a child has a caretaker does *not* make the child ineligible for personal care.

Reimbursement for personal care services delivered to children enrolled in MO HealthNet's Managed Care Program are the responsibility of the health plan in which the children are enrolled. Charges for services provided to MO HealthNet Managed Care enrolled children may *not* be billed to MO HealthNet. Health plans participating in the MO HealthNet Managed Care program are responsible for arranging, authorizing and reimbursing for all personal care delivered to enrollees. For more information about MO HealthNet's Managed Care program, please reference Section 12.6 and 13.17.A(1).

13.15.B MEDICAL CRITERIA

The following is a list of examples of medical problems that meet the criteria for medical necessity for personal care services for children. This list is *not* exhaustive and only provides a guideline of conditions.

Children who:

- have poorly controlled seizures, other than severe generalized tonic/clonic (grand mal) seizures;
- require assistance with orthotic bracing, body casts, or casts involving one full limb or more. (A typical short or long arm cast on an otherwise healthy child does *not* necessitate services of a personal care aide);

- are incontinent of bowel and/or bladder at age four and after. (Chronic bedwetting and encopresis are excluded);
- have persistent and/or chronic diarrhea, regardless of age;
- have significant central nervous system damage affecting motor control;
- have organically based feeding problems; or
- require assistance with activities of daily living. This applies to children unable to perform *age appropriate* functions of bathing, maintaining a dry bed and clothing, toileting, dressing, and feeding. Children with a diagnosis of developmental or intellectual disability may be eligible for personal care; if their ability to perform age appropriate personal care is impaired.

The following are examples of cases where personal care services are *not* appropriate for a child:

- Cases that require skilled nursing services. These services are available through the Home Health and the Private Duty Nursing Programs.
- Personal care for any child when there is no documented medical need for the care. For example, personal care for a healthy infant or toddler with no medical problems is inappropriate, as parents or other caregivers are expected to meet those needs as a normal function of parenting. However, when a child's personal care needs are greater than those of a healthy child of the same age, because of a medical condition or disability, then personal care may be appropriate to assist the caregiver in meeting those additional needs.
- Respite or baby-sitting service. Personal care services *must* include the performance of direct hands-on assistance and *cannot* consist solely of oversight or supervision. If a parent *must* be gone from the home when the personal care is needed, a personal care aide may deliver the service while the parent is absent, as long as the child has a medical need for the service.
- Homemaker-only service. While some homemaking service is appropriate through the Personal Care Program, such as changing bed linens or meal preparation and clean-up, homemaker services should represent only a small portion of the Personal Care Plan for Children. A parent or caretaker who is unable to perform the homemaking tasks because of their own disability may be referred to the Division of Senior Services and Regulation for assessment. In these cases, both the parent and child may be authorized for personal care services.

13.15.C EXAMPLE CASES

The following describe cases where personal care is appropriate. These examples are not all inclusive, and are not intended to describe the only situations in which personal care for children may be authorized. These case descriptions are meant to be used as a guide for providers to use in deciding whether or not to accept a referral and to request prior authorization.

- A 13-year-old child who uses a wheel-chair, and needs assistance with breakfast and getting ready for school. The parent must leave for work at 6:30 in the morning, too early to get the child ready for the bus. The child is of an age appropriate to get his own breakfast and get dressed for school. Personal care is appropriate for this child with disabilities and with a care plan specific to his needs.
- A 15-year-old child with disability who weighs 150 lbs. needs personal care. The parent is at home, and is available to provide the care; however, the child is too large for the parent to manage safely alone. Personal care is appropriate in this case.
- A parent has four children, ages 5 and under. The 5-year-old child needs personal care due to a medical condition. The other three children have no medical problems. If the child were an only child, personal care is questionable, in spite of the disability, because of the availability of the parent. However, the needs of the 3 additional children render the parent unavailable to meet the extra personal care needs of the child with disabilities.
- An emancipated young adult under 21, with personal care needs following surgery or an injury.

13.15.D FAMILY AS CAREGIVERS

- The availability of the parent should be considered when developing a care plan, but should *not* be a reason why personal care is denied. The care plan should describe in detail why the parent is unable to provide personal care themselves, or why they need assistance.
- A parent's or other caregiver's outright refusal to accept some responsibility for the care of a child should be reported to the Child Abuse/Neglect hotline. The personal care plan *must* be implemented with some assistance and cooperation of the normal caregiver.
- The aide employed by the agency who actually delivers the personal care service *must not* be a family or household member.

13.15.E CARE PLAN DEVELOPMENT AND RN SERVICE

The initial Personal Care Plan for Children *must* be developed by an RN. The agency may bill MO HealthNet separately for the initial evaluation and care plan development, when a face-to-face evaluation of the child is conducted. An evaluation procedure code, which does *not* require prior authorization, may be billed twice per year, per agency, per child. The RN evaluation is reimbursed at the same rate as the prior authorized nurse visit in the Personal Care Program designed for the adult population. The RN assesses and evaluates the child, develops the care plan, and obtains the physician's approval. The care plan and the physician's approval *must* be submitted to the Bureau of Special Health Care Needs with the Prior Authorization Request. (See Section 14 for details.)

Based on the care plan developed by the RN the personal care provider submits a request for approval for a specific number of units of personal care service to be delivered to the child. The personal care plan should specify the number of units per day, the frequency they will be delivered, the duration of service (how many weeks or months) and the specific tasks the aide is expected to perform. Personal care is authorized in one-month increments for up to 6 months per Prior Authorization Request.

The provider may request prior authorization for additional nurse visits, on a weekly basis, if the care plan indicates the child's condition may change and should be reassessed frequently. The authorized nurse visit may be used also for extra supervision of the aide. For example, in the case of a child with chronic diarrhea, nurse visits may be necessary to reassess the care plan frequently, as well as to monitor the child's skin condition.

The personal care provider may request prior authorization for RN visits to evaluate the child prior to requesting reauthorization, if this *must* be done more often than twice per year. If assessment is required twice per year or less, it should be billed via the nurse evaluation procedure code, which does *not* require prior authorization.

The authorized nurse visit in the Personal Care Program should not be confused with the services available through the Home Health Program. Cases in which the nurse is needed for skilled treatment of acute conditions should be authorized for the skilled nurse visit in the Home Health Program or the Private Duty Nurse Program.

13.15.F ADVANCED PERSONAL CARE SERVICES FOR CHILDREN

Children who require devices and procedures relating to altered body functions may be eligible for advanced personal care services. The provider agency may request prior authorization from the Bureau of Special Health Care Needs. Advanced personal care services for children must be delivered in accordance with the training and supervisory requirements for advanced personal care, as described in Section 13.9 of this manual.

In developing the care plan that includes advanced personal care, the provider must be specific about the length of time that is required each day for advanced personal care. Only the times designated specifically as advanced personal care may be reimbursed at the higher rate. All other time must be authorized and reimbursed at the basic personal care rate.

13.15.G MEDICALLY FRAGILE ADULT WAIVER PROGRAM

The Medically Fragile Adult Waiver Program was designed to provide home and community-based services to individuals who have reached the age of 21 and are no longer eligible for services through the Healthy Children and Youth Program. Private duty nursing, specialized medical supplies, and waiver attendant care services may be authorized through this waiver. Services for the Medically Fragile Adult Waiver Program require prior authorization by the Bureau of Special Health Care Needs.

13.16 SCHOOL-BASED INDIVIDUALIZED EDUCATION PLAN DIRECT SERVICES

Personal Care Individualized Education Plan (hereafter referred to as PC IEP) services are included in the school-based IEP services program for public schools. The program allows for the school district to receive the federal match portion of the funds allocated for certain medical services. Only the services identified in the IEP and up to the amount and duration identified in the IEP will be considered reimbursable.

School-based PC IEP services offers medically oriented maintenance of services designed to assist with activities of daily living when the assistance does not require devices and procedures related to altered body functions. PC IEP services are medically oriented tasks that are reviewed and approved or certified by a physician as the care necessary to meet a participant's physical needs and thereby enable the participant to be treated on an outpatient basis rather than in a hospital or nursing facility. PC IEP services are intended to meet personal, physical requirements and to meet needs that cannot be met by other resources. PC IEP services must be provided by a qualified individual who is not a member of the participant's family or household. The school district must monitor the overall physical care needs of the participant while in the school setting and contact the participant's physician if the participant's condition warrants.

The procedure code for billing PC IEP services in a school setting is T1019 TM. This service is billed in 15 minute increments. All services must be logged and billing is based on the time spent providing a covered service. Observation and waiting time are not covered.

To participate in the school-based PC IEP program, the billing provider of the services must be a recognized public school district in the State of Missouri by the Department of Elementary and Secondary Education. These services are billed by and reimbursement is made only to the school district. The school district may provide PC IEP services directly or through contract with a personal care provider agency.

If the school district chooses to contract for PC IEP services, the arrangements made by the school district with the actual Personal Care provider agency are between the school district and the provider agency. The personal care provider agency must be a MO HealthNet Division (MHD) enrolled personal care provider and cannot bill directly for MHD school-based PC IEP services.

For school districts who do not contract with a MHD enrolled personal care provider agency, all personal care requirements as set forth in 13 CSR 70-91 must be met. A school district providing direct personal care IEP services must meet the criteria for a personal care provider agency. The school district must submit a written proposal describing the service delivery system, assure understanding and compliance with the standards of the personal care program, and document the agencies administrative and fiscal ability to provide the services in accordance with these standards. Proposals will be reviewed by qualified medical staff or designees of the Department of Social Services (DSS).

The administrative requirements that must be addressed in the school district's written proposal are as follows:

- The school district shall maintain bonding, personal and property liability, and medical malpractice insurance coverage on all employees involved in delivering personal care IEP services.
- The school district must have a policy for responding to emergency situations.
- The school district must outline how qualified providers will be maintained, including supervisory requirements.
- The school district must outline available training and how training documentation will be maintained.
- The school district shall have a written statement of the participant's Bill of Rights, which shall be given to the parent/guardian at the time the service is initiated. At a minimum the statement should say the participant has the right to the following:
    1. Be treated with respect and dignity;
    2. Have all personal and medical information kept confidential;
    3. Have direction over the services provided as stated in the IEP;
    4. Know the school district's established grievance procedure and how to make a complaint about the service and receive cooperation to reach a resolution without fear of retaliation;
    5. Receive services without regard to race, creed, color, age , sex, or national origin; and
    6. Receive a copy of this Bill of Rights.

- The school district shall have a written grievance policy which shall be provided to each participant and parent/guardian upon initiation of services. The grievance policy must also include the phone number of the MO HealthNet Division, Participant Services Unit at 1-800-392-2161.
- The school district must report all instances of possible child abuse or neglect to the Child Abuse and Neglect (CA/N) Hotline, 1-800-392-3738. Any suspected abuse or neglect by a school district employee, including personal care staff, must be reported according to RSMo 210 and could be subject to prosecution. Failure to report by a mandatory reported (personal care staff would be considered mandatory reports) is a violation of RSMo 210.115 and could be subject to prosecution.
- The school district must maintain the distinction of a public school district with the Missouri Department of Elementary and Secondary Education.

Whether services are provided directly by the school district or through contact with a personal care agency, the PC IEP services are limited to those providers who meet licensing and supervisory requirements for the personal care IEP program as set forth in Section 13.16.A below.

13.16.A Personal Care Aide

A school-based personal care aide shall meet the following requirements:

- Be at least 18 years of age;
- Be able to read, write and follow directions;
- Have at least six (6) months paid work experience as an agency homemaker, nurse aide maid or household worker; or at least one (1) year of experience in caring for children, or for sick or aged individuals. Successful completion of formal training in the nursing arts, such as nursing aide or home health aide may substitute for the qualifying experience. This information must be verified and documented in the employee's file through reference checks or past paid or unpaid employers;
- May not be a family member, defined as a parent, sibling, or child by blood, adoption or marriage, of the participant for who personal care is to be provided;
- Must be available to provide care in accordance with the personal care plan, utilizing universal precaution procedures as defined by the Center for Disease control;
- Have received the following orientation and personal care training:

1. Orientation: 20 hours of orientation training that includes two (2) hours orientation to the school district and the school district protocols for handling emergencies,

eight (8) hours of classroom training completed prior to participant contact, and 10 additional hours of in-service training;

a) 12 hours of orientation may be waived with adequate documentation in the personal care aide's records that the aide received similar training during the current or previous state fiscal year or has been employed as an aide at an in-home or home health agency at least half-time for six (6) months or more with the current or preceding state fiscal year;

b) If the personal care aide is a certified nurse assistant, licensed practical nurse, or registered nurse, the school district may waive all orientation training, except the two (2) hours school district orientation, with documentation placed in the personal care aide's license or certification number current at the time the training was waived.

2. An additional 10 hours of in-service training annually that includes six (6) hours of classroom instruction and four (4) hours via any appropriate training method.

a) The school district may waive the required annual 10 hours of in-service training and require only two (2) hours of refresher training annually, when the personal care aide has been employed by the school district for three (3) years and has completed 30 hours of in-service training.

3. The school district shall have written documentation of all orientation and in-service training provided which includes, at a minimum, a report of each personal care aide's training that outlines the dates of all classroom or on-the-job training, trainer's name, topics, number of hours and location, the date of the first participant contact and includes the aid's signature. If a school district waives an in-service training, the employee's training record shall contain supportive data for the waiver.

13.16.B Supervision

The school district must employ an administrative supervisor of the day-to-day delivery of direct personal care IEP services that meets the following requirements:

- Be at least 21 years of age;
- Be a RN who is currently licensed in Missouri; or have at least a baccalaureate degree; or be a LPN who is currently licensed in Missouri with at least one (1) year of experience with the direct care of the elderly, disabled or infirm; or have at least three (3) years' experience with the care of the elderly, disabled or infirm;

- Establish, implement, and enforce a policy governing communicable diseases that prohibits contact with participants when the personal care aide has a communicable condition, including colds or flu;
- Monitor the provision of services by the personal care aide to assure that services are being delivered in accordance with the plan of care;
- Make an on-site visit with the personal care aide present at least annually to evaluate each personal care aide's performance and the adequacy of the plan of care, including review of the plan of care with the participant and his or her family. A written record of the evaluation shall be maintained in the personnel file of the personal care aide;
- Approve, in advance, all changes to the plan of care based on supervisory on-site visits, information from the personal care aide, or observation by the RN, or a combination of these, as noted and dated in the participant's file;
- Assist in orientation and personal care training for personal care aides and
- If the supervisor is not a RN, the school district must have a designated RN currently licensed in Missouri either on staff or employed as a consultant. The RN's responsibilities shall include, at a minimum, monthly in-person visits to a 10% sample of the personal care participants, and the initial/review of all on-site visit reports made by the personal care supervisor. If supervised by a RN, a LPN may perform the RN supervisory activities described in this section.

Services provided as documented in the IEP are reimbursed at the Federal Financial Participation (FFP) Rate. The remainder of the allowed amount is the responsibility of the school district originating the IEP. The MO HealthNet maximum allowable fee for each code can be found on the Internet at: http://www.dss.mo.gov/mhd/providers/pages/cptagree.htm.

All services included in the school-based PC IEP program must be billed by the school district. The school district will be considered the billing provider. The school district must bill the actual cost of providing the service.

The child receiving school-based PC IEP services must be eligible for MO HealthNet coverage for each date a service is rendered for reimbursement to be made. The child must be under the age of 21 years. All services rendered to a child must be billed under the child's individual MO HealthNet identification number.

The school district and the personal care provider must maintain a copy of the official public school generated IEP and the plan of care in the child's record to document the service as an IEP service.

Children enrolled in a MO HealthNet managed care plan receive school-based services that are identifiable in an IEP on a fee-for-service basis outside the MO HealthNet managed care benefit package.

13.16.C PROVIDER ENROLLMENT

Each school district interested in billing the MO HealthNet Division for school-based PC IEP services must enroll as a MHD provider. For all enrollment information, go to http://peu.momed.com/momed/presentation/commongui/PeHome.jsp.

School districts currently enrolled to provide school-based services who wish to expand to include PC IEP services must contact Missouri Medicaid Audit and Compliance (MMAC), Provider Enrollment Unit, to request the personal care IEP service be added to the school district's enrollment file. This request can be emailed to MMAC providerenrollment@dss.mo.gov; mailed to Missouri Medicaid Audit and Compliance, Attn: Provider Enrollment Unit, PO Box 6500, Jefferson City, MO 65102; or faxed to 573-526-2054.

If a school district contracts with a personal care agency to provide PC IEP services, the personal care agency must individually enroll with the MO HealthNet Division and meet the requirements outlined in 13 CSR 70-91.

Information provided on the enrollment application must agree with the information on file with the DESE.

13.16.D PLAN OF CARE

Services are considered school-based when they are included in an IEP as defined by the Individuals with Disabilities Education Act, Part B (34 CFR 300 and 301). In addition to the IEP, a plan of care must be developed and signed by a registered nurse (RN) and approved by a physician for a child receiving school-based personal care IEP services. Services must be provided as indicated in the IEP and plan of care. A child's plan of care must be evaluated at regular intervals.

The plan of care must specify:

- the diagnosis;
- the desired outcome;
- the nature of the treatment;
- the frequency of treatment (number of minutes per day/per week/per month); and
- the duration (weeks or months) of services.

The child or his/her family may not be charged for development of the plan of care. MO HealthNet does not reimburse the school district or personal care providers to participate in IEP meetings or when developing a plan of care for a child.

A provider signed plan of care must be maintained at the facility where services are performed and must be made available for audit purposes at any time. The MHD does not dictate a standardized plan of care.

The child's treatment record must also include all components, including adequate documentation as required in 13 CSR 70-3.030.

13.17 PERSONAL CARE SERVICE DELIVERY FOR PERSONS WITH AIDS

The AIDS Waiver Program provides home and community based treatment as a cost effective alternative to the institutional care for individuals living with HIV that have a decreased level of function due to their disease. All MO HealthNet-enrolled personal care providers that have completed the AIDS Waiver Program Addendum to the provider agreement are eligible to provide AIDS waiver personal care. Providers may wish to contact the Department of Health and Senior Services, Disease Prevention/Bureau of HIV, STD, and Hepatitis to indicate interest in receiving referrals for AIDS waiver personal care. For more information on the AIDS Waiver Program, please reference Section 13 of the AIDS Waiver Manual.

13.18 MANAGED CARE

13.18.A MANAGED CARE—MO HEALTHNET MANAGED CARE

Personal care and advanced personal care services are covered through the MO HealthNet Managed Care program for participants in certain MO HealthNet Managed Care regions. The participant's inclusion or exclusion from participation in one of the MO HealthNet Managed Care plans may be verified by contacting the interactive voice response (IVR) system at (573) 635-8908 or online at www.emomed.com.

13.18.A (1) Health Plan

All services covered by the health plans are billed to and paid by the plan. The health plan provider name and phone number is identified while verifying participant eligibility. The health plan provider *must* be contacted for approval prior to delivering services.

Services to be provided to a participant on or after the effective date of enrollment in a managed health care plan which were authorized by the state prior to the participant's enrollment with a health plan *must* be approved by the health plan.

13.19 PARTICIPANT NONLIABILITY

MO HealthNet covered services rendered to an eligible participant are *not* billable to the participant if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

13.20 PERSONAL CARE SERVICES AND THE HOSPICE PROGRAM

MO HealthNet covers hospice services for MO HealthNet eligible persons with a terminal condition whose life expectancy is six months or less. The Hospice Program provides palliative care, rather than active treatment. The Hospice Program includes the following services:

- Nursing care provided by or under the supervision of a registered nurse;
- Medical social services;
- Physician services performed by a doctor of medicine or osteopathy to meet the general medical needs of the participant to the extent that these needs are *not* met by the attending physician;
- Counseling services *must* be available to both the participant and the family members or other persons caring for the participant at home. Counseling, including dietary counseling, may be provided both for the purpose of training the participant's family member or other caregiver to provide care and for the purpose of helping the participant and those caring for him/her to adjust to the participant's approaching death; bereavement and spiritual counseling;
- All drugs (prescription or over the counter) and biologicals used primarily for pain or symptom control of the terminal illness;
- Short term inpatient care required for pain control or acute or chronic symptom management;
- Short term inpatient respite care (if provided in a nursing facility (NF), the NF must have 24-hour RN coverage);
- Medical appliances and supplies related to the participant's terminal illness. This includes covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the participant's terminal illness. Medical supplies include those that are part of the written plan of care;
- Room and board in a MO HealthNet-certified nursing facility;
- Home health aide and homemaker services. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the participant such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the participant. Aide services *must* be provided under the general supervision of a registered nurse. Homemaker

services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care; and

- Physical therapy, occupational therapy, and speech-language services for purposes of symptom control or to enable the participant to maintain activities of daily living and basic functional skills. Hospice participants are "locked in" to the hospice provider and *must* receive all of their medical care related to their terminal illness through the hospice provider with a few exceptions. Personal care and home and community based waiver services are among the exceptions.

When personal care services are required which are beyond the scope of the home health aide and homemaker services covered under the hospice benefit, the state agency case manager may authorize additional services to be provided by a personal care provider. The state case manager *must* work closely with the hospice provider to develop a personal care service authorization that does *not* duplicate, but augments, the aide services the hospice *must* provide.

When authorizing personal care services for a participant who has elected hospice, the case manager should indicate that a hospice is also providing care and who the hospice provider is.

If it is discovered while serving a participant that a hospice provider is also involved and if the referral information does not indicate that the state case manager is aware of the hospice election, please notify the case manager. Hospice participants are identified while verifying participant eligibility by contacting the interactive voice response (IVR) system at (573) 635-8908 or online at www.emomed.com.

13.21 PROVIDER REASSESSMENTS

Home and Community-Based Services (HCBS) providers have the option to partner with the Division of Senior and Disability Services (DSDS) to gather the necessary information in order for DSDS to determine continued eligibility for HCBS. If a provider chooses not to participate in the reassessment and care planning process, DSDS will reassess the participant.

13.21.A PROVIDER REQUIREMENTS

- If a provider chooses to assist with the reassessment of participants the following criteria must be met:
- HCBS providers must complete a reassessment packet with Missouri Medicaid Audit and Compliance (MMAC) and must have been approved by MMAC as a reassessment provider in order to complete and bill for the completed reassessments.
- Each month a list of participants requiring reassessment is sent by DSDS to each provider through SharePoint. Providers must only complete and bill for reassessments of participants that are included in the lists provided by DSDS.

Reassessments completed by qualified providers may only be billed for participants when appearing on the list provided by DSDS. Providers may bill only once for these reassessments.

- A provider must ensure that all reassessments are completed by:
  1) Provider staff that have either attended the DSDS sponsored train the trainer classes and passed the test OR
  2) Provider qualified staff that has been trained by an individual who has attended and passed the train the trainer class. A list of all individuals who have passed the train the trainer test is maintained on the DHSS website at http://health.mo.gov/seniors/hcbs/.
- Providers must maintain all appropriate documentation to verify that the reassessment was completed. This documentation should indicate on what date the reassessment was completed and what provider staff member completed the reassessment.
- Documentation of the reassessment training must be kept in the personnel file of the individual completing the reassessment if the staff member completing the reassessment is not listed on the DSDS maintained Trainer list, Documentation within the personnel file must include the name of the individual who provided the training and the date that the training occurred.

END OF SECTION

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SECTION 14 - SPECIAL DOCUMENTATION REQUIREMENTS

14.1 REQUIREMENTS

All services covered by the Title XIX Medicaid Personal Care Program *must* be prior authorized by a Missouri State Agency, or its designee. The specific state agency responsible for authorizing any given personal care service is dependent upon the Medicaid Program under which the participant is potentially eligible to receive services under.

If personal care is to be provided to an elderly or disabled individual 18 years of age or older, the authorizing state agency is the Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS). If a participant has been diagnosed with the AIDS virus or is HIV positive, their care may be managed and authorized through care coordinators for HIV/AIDS services under the Section for Disease Prevention, Bureau of HIV, STD, and Hepatitis under DHSS, for more information regarding those participants receiving services through the AIDS Waiver please refer to the AIDS Waiver Manual. For children under 21 years of age, the involved state agency is the Bureau of Special Health Care Needs (BSHCN) under Section for Community Health Services and Inititiaves with DHSS. Clients may *not* always clearly fall under any one of the described state agencies case management programs; however, this basic information is provided as a guide.

Each state agency utilizes assessment and authorization processes unique to their program. All services authorized by the DSDS or its designee are authorized utilizing the Home and Community Based Services (HCBS) Web Tool, a component of the Department of Social Services, MO HealthNet Division's (MHD) CyberAccess[sm] system. HCBS providers can receive Web Tool guidance by reviewing the HCBS Web Tool Instructional Guide at the following link; https://health.mo.gov/seniors/hcbs/webtoolresources.php

The provider must access a participant's care plan from the Participant Case Summary screen in the HCBS Web Tool. This screen provides specific information pertaining to the participant's case. The Case Items section of this screen gives a listing of case stages and a view of the HCBS prior authorizations. The case line will display the 'Prior Authorization (PA) – Care Plan'.

> Note: A 'Posted' status indicates that a prior authorization number (PA#) has been submitted to MMIS. A PA# in 'Pending' status does not ensure payment for any services delivered.

Each posted 'Prior Authorization – Care Plan' will have a specific number assigned to aid in identification. To view the specific services and associated provider(s) authorized for the participant, expand the selected 'Prior Authorization – Care Plan'. This view includes the following information: HCBS authorized; period of time covered by the authorization; the total units per month, and the PA# assigned to the service. Expanding each individual HCBS line provides display of the service tasks (if applicable) and the service frequency. A print icon to the left of the 'Prior Authorization – Care Plan' is available when a paper copy of the care plan is required.

The effective date for the authorization cannot precede the completion date of the assessment. The end date for the authorization shall *not* exceed the last full month within 365 days from the completion date of the assessment.

The provider should be aware that if a participant loses Medicaid eligibility or coverage during an authorized period of time, services are *not* reimbursed for the ineligible dates, the posted prior authorization notwithstanding. Refer to Section 1 of this manual for details about participant eligibility.

Providers should make sure that the participant's name and identification number on the authorization match the participant's MO HealthNet ID card, and that the Prior Authorization – Care Plan Services screen contains the provider's correct name for the service to be provided. If any of these items are incorrect, the provider should immediately contact the state agency or its designee to initiate a correction.

In addition to the Prior Authorization – Care Plan Services screen, the provider has access to scanned documents (e.g., Participant Choice Statement) in addition to Case Notes within the participant's electronic health record by navigating to the Case Activity Screen.

Additionally, the provider has access to the following information in the participant's electronic health record.

- PreScreen (read only); and
- Assessment Screen.

All documents become a part of the fiscal and medical records which *must* be retained to document services billed to MO HealthNet. Any document used to bill MO HealthNet for services rendered (e.g., care plan/authorization, time sheets), *must* be retained for five years and open to inspection as specified in Section 13 of this manual.

The remainder of the section deals with several of the forms utilized in requesting and documenting personal care services.

14.2 SUPERVISORY MONITORING/DELIVERY LOGS

Each personal care provider is required to monitor and document the actual delivery of service. Documentation *must* also reflect the number of approved units versus the number of units actually delivered.

To accomplish this documentation requirement, a routine review and comparison of the aides' logs of services versus the service authorizations for each participant *must* be completed. The units of service authorized, the tasks specified, and the authorized frequency of delivery *must* be compared to the units, tasks, and frequency of delivered services. A written explanation of any discrepancies and description of corrective action taken *must* be signed and dated by the supervisor and be readily available for monitoring or inspection. The procedures for reporting to either the Division of Senior and Disability

Services or the Prevention and Care Programs are discussed in Sections 14.2.A and 14.2.B of this manual.

14.2.A DIVISION OF SENIOR AND DISABILITY SERVICES—SUPERVISORY DELIVERY MONITORING REQUIREMENTS

Supervisors are required to monitor the provision of services by the personal care aide to ensure that services are being delivered in accordance with the personal care plan. This should be primarily in the form of an at least monthly review and comparison of the service participant/aide's log of provided services with the personal care plan. The monitoring reports *must* be available for review by the Departments of Social Services and Health and Senior Services upon request. Documentation *must* be kept on participants with a delivery rate of less than 80 percent of the authorized units of in-home service. This documentation *must* be retained in the participant's file. A written record describing the discrepancies between the frequency of delivered services and/or the in-home service tasks delivered and the corrective action taken, *must* be signed and dated by the supervisor and be readily available for review.

14.3 REQUESTING PRIOR AUTHORIZATION FOR PERSONAL CARE SERVICES FOR CHILDREN

A personal care provider may receive a referral from a hospital discharge planner, a family member, a physician, or other source, requesting personal care on behalf of a child. The personal care provider *must* take the following steps to request approval for service delivery to a child:

- A plan of care *must* be developed listing the duties of the personal care aide, duties of the nurse (if required) and the duration and frequency of the visits. This may be done by the provider agency's RN.

An example of a plan of care is found in Section 14.5. The provider may photo copy and use the example, or develop their own, as long as it contains sufficient information specifying the amount of personal care and tasks to be performed.

- Physician approval *must* be obtained which documents the child's medical condition and the need for personal care services. Physicians may approve personal care services:
  - by signing the completed Prior Authorization Request form;
  - by writing an order or prescription for personal care, specifying the medical condition requiring the care;
  - by signing a photocopy of the Physician Certification form found in Section 14.4;
  - by signing a CMS 485, or another form similar to the format suggested in this Section 14.4. The physician certification should contain information verifying the medical diagnosis and the personal care plan.

- A Prior Authorization Request form *must* be completed and sent to the Bureau of Special Health Care Needs office serving the county of the child's residence. An example of this form is found in Section 8. General instructions for completing the form are found on the back of the form. This form may be ordered from the fiscal agent. (See Section 3 of this manual.)

The following are instructions for the Prior Authorization Request form as it applies to personal care for children:

Section I	General Information	Complete as instructed on back.
Section II	HCY (EPSDT) Service Request	Completion of this section is at the option of the provider requesting services. The date the child was seen by the physician ordering the personal care service may suffice as the date of the HCY screen, entered in Field #10.
Section III	Service Information:	
	Field #16:	(Reference Number) a unique designator (1 – 12) identifying each separate line on the request.
	Field #17:	Procedure Code: See Section 19.
	Field # 18	Enter the appropriate modifier(s) for the services being requested.
	Field #19:	Enter the first date services will begin if authorization is approved (mm/dd/yy) format
	Field #20:	Enter the date services will terminate if authorization is approved (mm/dd/yy). This date is the end of that month. For example, if services are requested to begin January 15, the end date *must* be January 31. Up to six months of service may be requested per form, one month on each line.
	Field #21:	Description of Services
	Field #22:	Enter the total number of units for the month requested in Fields #19 and #20. NOTE: Services for children provided through the HCY Program may exceed the limits of the State Plan. Therefore, children are *not* subject to a cap on the number of units received in one month. The number of units requested *must* be directly linked to

		the medical need of the child, and supported by the plan of care and the physician's orders.
	Field #24:	No entry necessary, if there is a separate attachment containing the description of the medical condition with the physician's authorization.
Section IV	Provider	Complete as instructed on back of form. A signature is *not* required; however, the name of the contact person within the agency is helpful, in case the Bureau of Special Health Care Needs has questions about the request.
Section V	Prescribing/Performing Practitioner	If attaching a copy of the physician approval for the personal care service as described above, completion of this field is *not* necessary. If physician's orders are *not* supplied as a separate attachment, then the prescribing physician's signature *must* be obtained on the Prior Authorization Request form.

A sample of the Physician Certification is found in Section 14.4. This form may be photo copied and used, or the provider may use another format, such as the physician signature on the ITP, as long as it contains sufficient information about the services required and the physician's signature and date.

The Bureau of Special Health Care Needs (BSHCN) approves or denies the request for prior authorization of services. Prior Authorization Requests for in-home services for children *must* be sent to the BSHCN. Reference Bureau of Special Health Care Needs Area Offices map for a directory of the locations and addresses of the Bureau offices. The Prior Authorization Request form should be sent to the Bureau office serving the county of the child's residence.

The Prior Authorization Request form is forwarded by the BSHCN to the fiscal agent for keying. The fiscal agent returns a Missouri Medicaid Authorization Determination to the provider. The Missouri Medicaid Authorization Determination serves as notification to providers of approvals or denials.

14.3.A REAUTHORIZATIONS

Reauthorization requests should be submitted to the Bureau during the last month of the current authorization period, to allow plenty of time for review and approval. Follow the same steps as listed above to request reauthorizations.

The reauthorizations should document progress or changes in the child's medical needs. The documentation should support the continuation of service, or explain why changes in level of service are planned.

Archived

14.4 PHYSICIAN CERTIFICATION OF NEED FOR PERSONAL CARE SERVICES FOR CHILDREN UNDER THE AGE OF 21

The Physician Certification of Need for Personal Care Services is *not* a standard form. The provider may create a form, as long as it contains sufficient information, or make copies of the following sample.

From: _____
(agency name)

_____
(agency address)

To: _____
(physician name)

_____
(physician address)

Re: _____
(participant name)

_____
(participant MO HealthNet ID number (DCN))

_____
(birthdate)

_____
(Medical diagnosis and description)

The above-named child under the age of 21 has been referred to our agency for the delivery of personal care services. Your approval of these services is necessary before we may request prior authorization from the Bureau of Special Health Care Needs. The following is a care plan describing the amount, duration, and scope of services to be delivered to the child:

_____
(Registered Nurse Signature)

_____
(date verbal start of care received from physician)

The above patient is under my care, and I certify the services as described in the above care plan are medically necessary. The need for personal care will be reviewed by me at least every six months.

_____
(signature of physician)

_____
(date signed)

Archived

14.4.A REQUESTING A CHANGE TO AN APPROVED PRIOR AUTHORIZATION

If the personal care provider agency determines that it is necessary to request a change to an approved Prior Authorization Request, agency staff *must* submit this request through the BSHCN.

14.5 PERSONAL CARE PLAN FOR CHILDREN

The Personal Care Plan for Children is not a standard form. The provider may create a form, as long as it contains sufficient information, or make copies of the following sample.

Child's Name: _____ MO HealthNet ID Number (DCN): _____

Authorization Period: _____

Describe the medical condition that supports medical necessity of personal care: _____

_____

Amount and frequency of services: _____

Personal Care Aide Tasks: (check all that apply)

____ Meal preparation and clean up, including special diet menus.

____ Make beds and change sheets, with child in or out of bed, as required.

____ Brush, comb, shampoo hair.

____ Bathing, bed baths, tub baths, or other.

____ Brush teeth, dentures.

____ Cut and clean toenails (except diabetic).

____ Shave with electric or safety razor.

____ Instruct child and family in ways to become self-sufficient in personal care.

____ Assist with eating, feeding helpless child.

____ Laundry relating to the child's needs, (bed linens, child's clothing).

____ Household tasks directly relating to the child's needs.

____ Assistance with transfers when child is weight bearing.

____ Lifting of child who weighs 35 lbs. or less

Advanced Personal Care Tasks (check all that apply)

____ Manually Assist with Oral Medications (medications *must* be set up by LPN/RN).

____ Apply prescription topical ointment/lotions to skin.

____ Catheter Care (external, indwelling, suprapubic)

____ Removal of External Catheters

____ Ostomy Care (well healed stoma only) Tracheostomy, Gastrostomy, Colostomy

____ Administer Bowel Program

____ Passive Range of Motion

____ Apply Non-Sterile Dressings (Superficial skin breaks or abrasions only)

____ Use Lift to Transfer

Authorized RN visits (check all that apply):

____ Increased supervision of the aide.

____ Re-evaluation of child's health, skin condition.

____ Nail care for diabetics or other contraindicating conditions.

____ Set up oral medications for parent to administer, or for emancipated young adult.

____ Set up injections for parent to administer, or for emancipated young adult.

For last two RN tasks, describe why parent is unable to set up medication: _____

_____

Name of RN completing care plan: _____

Signature: _____ Date: _____

14.6 HOME AND COMMUNITY BASED SERVICES (HCBS) REFERRAL

Referrals for Home and Community Based Services (HCBS) can be made to the Division of Senior and Disability Services (DSDS), or its designee, by utilizing the Home and Community Based Services Referral form (HCBS-1). The HCBS-1 is designed to provide DSDS with information to verify prescreen eligibility and determine probable service needs. The HCBS-1 can be found within the HCBS Manual, Chapter 8 (Miscellaneous and Forms), Appendix 3 at http://health.mo.gov/seniors/hcbs/hcbsmanual/index.php. Providers and professional community partners are encouraged to submit HCBS-1 forms to HCBSCallCenterReferrals@health.mo.gov. Potential participants, or their representatives, are encouraged to contact the HCBS Call Center toll free at 866-835-3505 to complete the intake and prescreen process.

14.7 HOME AND COMMUNITY BASED SERVICE (HCBS) CARE PLAN AND PARTICIPANT CHOICE STATEMENT

The Participant Choice Statement form is used by the Division of Senior and Disability Services and allows documentation of the participant's involvement in determining the plan of care by including the participant's acknowledgment of his/her:

- participation in the development of the person centered care plan;
- right to have anyone involved in the development of the person centered care plan;
- right to choose and receive home and community based services or nursing facility care;
- loss of services due to discriminatory behavior regarding service delivery;
- expectations and responsibilities;
- right to choose a qualified home and community based provider; and
- need to notify the DHSS' Central Registry Unit (CRU) to report abuse, neglect, or exploitation
- need for notifying the appropriate DSDS Regional Evaluation Team of any problems concerning service delivery as well as changes in health, formal and informal supports, satisfaction with the services provided, and/or functioning status that might require care plan adjustment.

The Participant Choice Statement form is completed by the Division of Senior and Disability Services or its designee upon initial assessment and any subsequent assessment. DSDS or its designee reviews the information covered on the form with the participant and ensures the participant's understanding of the information. The document is scanned and attached in the participant's electronic health record in the HCBS WebTool. A copy is provided to the participant.

14.8 PRIOR AUTHORIZATION CARE PLAN SERVICES

The Prior Authorization – Care Plan Services screen is completed by DSDS or its designee, and is designed to provide information to the participant and provider identifying the specific service(s) to be provided.

The Prior Authorization Care Plan Services screen is a component of the HCBS Web Tool and can be accessed by the provider. A copy of the initial and all subsequent care plans are sent to the participant. An initial copy is sent to the physician.

14.9 AUTHORIZATION OF CARE PLAN CHANGES IN HOME AND COMMUNITY BASED SERVICES WEB TOOL

When an existing care plan requires a **decrease** in authorized services, Division of Senior and Disability Services' (DSDS) staff will enter the effective date of change in the HCBS WebTool as the first day of the first month following the date the change is made. This change applies regardless of whether the need for decrease is identified in mid-authorization or at reassessment. This also applies when there is a need for a decrease due to cost cap adjustment.

If there are **no changes** required to the person centered care plan upon reassessment, DSDS staff will enter the effective date of change in the HCBS WebTool as the first day of the first month following the date of reassessment.

While all efforts will be made to avoid mid-month care plan changes as described above, certain circumstances may require the authorization change to be made during the month. In these circumstances, providers shall not bill more units than the higher of the two authorizations for the month, and providers shall not bill for units not delivered. Units billed in excess of the higher of the two authorizations or for services not delivered are subject to recoupment.

DSDS will continue to follow current protocol for care plans when a need for an **increase** is identified druing reassessment or following a request for a care plan change. This means the effective date may fall during the middle of the month. When this happens, two authorizations are active at the same time for that month. However, one authorization **ends** on the date prior to the increase and one authorization begins on the date of the increase through the end of that authorization period. Again, providers must not bill more than the total units of the higher of the two care plan authorizations, and the provider shall not bill for units not delivered. Units billed in excess of the higher of the two authorizations or for services not delivered are subject to recoupment.

14.10 HOME AND COMMUNITY SERVICES REGIONAL EVALUATION TEAMS MAP

A copy of the Division of Senior and Disability Services, Regional Evaluation Team map may be found by accessing the following link: http://health.mo.gov/seniors/homecomservices/pdf/BHCS-EvalTeam.pdf.

END OF SECTION

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SECTION 15-BILLING INSTRUCTIONS

15.1 ELECTRONIC DATA INTERCHANGE

Billing providers who want to exchange electronic transactions with MO HealthNet should access the ASC X12N Implementation Guides, adopted under HIPAA, at http://www.wpc-edi.com. For Missouri specific information, including connection methods, the biller's responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the X12N Version v5010 and NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guides found through this web site. To access the Companion Guides, select:

- MO HealthNet Electronic Billing Layout Manuals
- System Manuals
- Electronic Claims Layout Manuals
- X12N Version v5010 or NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guide.

15.2 INTERNET ELECTRONIC CLAIM SUBMISSION

Providers may submit claims via the Internet. The web site address is www.emomed.com. Providers are required to complete the on-line Application for MO HealthNet Internet Access Account. Please reference http://dss.missouri.gov/mhd for further information. Providers are unable to access www.emomed.com without proper authorization. An authorization is required for each individual user.

The following claim types can be used in Internet applications: Medical (NSF), Inpatient and Outpatient (UB-04), Dental (ADA 2002, Version 2004), Nursing Home and Pharmacy. For convenience, some of the input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

15.3 CMS-1500 CLAIM FORM

The CMS-1500 claim form is always used to bill MO HealthNet for personal care services unless a provider bills those services electronically. Instructions on how to complete the CMS-1500 claim form are on the following pages.

15.4 PROVIDER COMMUNICATION UNIT

It is the responsibility of the Provider Communication Unit to assist providers in filing claims. For questions, providers may call (573) 751-2896. Section 3 of this manual has a detailed explanation of this unit. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via the Internet, network communications, or ongoing operations, the provider should contact the Wipro Infocrossing Help Desk at (573) 635-3559.

15.5 RESUBMISSION OF CLAIMS

Any line item on a claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny *must* be corrected before resubmitting the claim. The provider may resubmit electronically or on a CMS-1500 claim form. If a line item on a claim paid but the payment was incorrect do *not* resubmit that line item. For instance, if the claim showed 10 units of service but should have shown 16 units of service, that claim *cannot* be resubmitted. It will deny as a duplicate. In order to correct that payment, the provider *must* submit an Individual Adjustment Request. Section 6 of this manual explains the adjustment request process.

15.6 CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet claims should be mailed to:

Wipro Infocrossing
P.O. Box 5600
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of this manual.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields *must* be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1. Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box; if a MO HealthNet claim is being filed, check the Medicaid box; and if the participant has both Medicare and MO HealthNet, check both boxes.

*1a.	Insured's I.D. Number	Enter the participant's eight (8) digit MO HealthNet or MO HealthNet Managed Care ID number (DCN) as shown on the participant's ID card.
*2.	Patient's Name	Enter last name, first name, middle initial *in that order* as it appears on the ID card.
3.	Patient's Birth Date	Enter month, day, and year of birth.
	Sex	Mark appropriate box.
**4.	Insured's Name	If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete Fields #6, #7, #11, and #13. If no private insurance is involved, leave blank.
5.	Patient's Address	Enter address and telephone number if available.
**6.	Patient's Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
**7.	Insured's Address	Enter the primary policyholder's address; enter policyholder's telephone number, if available. If no private insurance is involved, leave blank.
8.	Patient Status	Not required.
**9.	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. (See Note)(1)
**9a.	Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. (See Note) (1)
**9b.	Reserved for NUCC Use	Leave Blank
**9c.	Reserved for NUCC Use	Leave Blank

**9d.	Insurance Plan Name or Program Name	Enter the other insured's insurance plan or program name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* If no private insurance is involved, leave blank. (See Note) (1)
**10a-10c.	Is Patient's Condition Related to:	If services on the claim are related to participant's employment, auto accident, or other accident, mark the appropriate box. If the services are *not* related to an accident, leave blank. (See Note) (1)
10d.	Claim Codes (Designated by NUCC)	Leave Blank
**11.	Insured's Policy or FECA Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. (See Note) (1)
**11a.	Insured's Date of Birth, Sex	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. (See Note) (1)
**11b.	Other Claim ID (Designated by NUCC)	Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC.
**11c.	Insurance Plan Name	Enter the primary policy-holder's insurance plan name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan*. If no private insurance is involved, leave blank. (See Note) (1)
**11d.	Other Health Plan	Indicate whether the participant has another health insurance plan; if so, complete Fields 9-9d with the secondary insurance information. If no private insurance is involved, leave blank. (See Note) (1)
12.	Patient's Signature	Leave blank.

**13.	Insured's Signature	This field should be completed only when the participant has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider or MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14.	Date of Current Illness, Injury, or Pregnancy	Leave blank.
15.	Date Same/Similar Illness	Leave blank.
16.	Dates Patient Unable to Work	Leave blank.
**17.	Name of Referring Provider or Other Source	Enter the name of the referring provider or other source. If multiple providers are involved, enter one provider using the following priority order: 1. Referring provider 2. Ordering Provider 3. Supervising Provider
**17a.	Other ID #	Enter the Provider Taxonomy qualifier ZZ in the first shaded area if the provider reported in Field #17b is required to report a Provider Taxonomy Code to MO HealthNet. Enter the corresponding 10-digit Provider Taxonomy Code in the second shaded area for the provider reported in Field #17b.
**17b.	NPI	Enter the NPI number of referring, ordering, or supervising provider.
18.	Hospitalization Dates	Leave blank.
19.	Reserved for Local Use	Providers may use this field for additional remarks/descriptions.
20.	Lab Work Performed Outside Office	Leave blank.

*21.	Diagnosis	Enter the complete current International Classification of Diseases-Clinical Modification (ICD-CM) diagnosis code(s). Enter the primary diagnosis under No. 1, the secondary diagnosis under No. 2, etc.
**22.	MO HealthNet Resubmission	For timely filing purposes; if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23.	Prior Authorization Number	Leave blank.
*24a.	Date of Service	Enter the date of service under "from" in month/day/year format, using six-digit format in the unshaded area of the field. All line items *must* have a from date. The six (6) service lines have been divided to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top area of the service lines are shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service
*24b.	Place of Service	Enter the appropriate place of service code in the unshaded area of the field. For personal care enter 12, "Home"
24c.	EMG-Emergency	Leave blank.
*24d.	Procedure Code	Enter the appropriate CPT or HCPCS code and applicable modifiers, if any, corresponding to the service rendered in the unshaded are of the field. (Field #19 may be used for remarks or descriptions) See Section 19 of this manual for applicable procedure codes.

*24e.	Diagnosis Pointer	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from Field #21 in the unshaded area of the field.
*24f.	Charges	Enter the provider's usual and customary charge for each line item in the unshaded are of the field. This should be the total charge if multiple days or units are shown.
*24g.	Days or Units	Enter the number of days or units of service provided for each detail line in the unshaded area of the field. *The system automatically plugs a "1" if the field is left blank.* A unit of service equals 15 minutes.
**24h.	EPSDT/Family Planning	If the service is an EPSDT/HCY screening service or referral, enter "E". If the service is family planning related, enter "F". If the service is both EPSDT/HCY and Family Planning enter "B".
**24i.	ID Qualifier	Enter the Provider Taxonomy qualifier ZZ in the shaded area if the rendering provider is required to report a Provider Taxonomy Code to MO HealthNet. A Provider Taxonomy Code must be reported if providers have one NPI for multiple legacy MO HealthNet provider numbers.
**24j.	Rendering Provider ID	If the Provider Taxonomy qualifier was reported in Field #24I; enter the 10 digit Provider Taxonomy Code in the shaded area. Enter the 10 digit NPI number of the individual rendering the service in the unshaded area.
25.	SS #/Fed. Tax ID	Leave blank.
26.	Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27.	Assignment	Not required on MO HealthNet claims.
*28.	Total Charge	Enter the sum of the line item charges.

29.	Amount Paid	Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and copay amounts are *not* to be entered in this field.
30.	Balance Due	Enter the difference between the total charge (Field #28) and the amount paid (Field #29).
31.	Provider Signature	Not required.
**32.	Name and Address of Facility	If services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.
**32a.	NPI#	Enter the 10 digit NPI number of the service facility location in Field #32.
**32b.	Other ID#	Enter the Provider Taxonomy qualifier ZZ and corresponding 10 digit Provider Taxonomy Code for the NPI number reported in Field #32a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do no enter a space, hyphen or other separator between the qualifier and code. A Provider Taxonomy Code must be reported if providers have one NPI for multiple legacy MO HealthNet provider numbers.
*33.	Provider Name/Number/Address	Enter the provider's name, phone number and address.
**33a.	NPI#	Enter the NPI number of the billing provider in Field #33.
**33b.	Other ID#	Enter the Provider Taxonomy qualifier ZZ and corresponding 10 digit Provider Taxonomy Code for the NPI number reported in Field #33a if the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and code.

These fields are mandatory on *all* CMS-1500 claim forms.

*

** These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information **only**. If no private insurance is involved LEAVE BLANK. If Medicare, MO HealthNet, employers name or other information appears in this field, the claim will deny. See Section 5 of this manual for further TPL information.

15.7 PLACE OF SERVICE CODES

CODE	DEFINITION	
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.

15.8 INSURANCE COVERAGE CODES

Type of insurance coverage codes identified on interactive voice response (IVR) system, or eligibility files accessed via the Internet are listed in Section 5 of this manual, Third Party Liability.

While providers are verifying the patient's eligibility, they can obtain the Third Party Liability (TPL) information contained on the MO HealthNet Division's participant file. Eligibility and TPL information may be verified by calling the (IVR) system at (573) 751-2896, by accessing the Internet at www.emomed. Reference Sections 1 and 3 of this manual for more information.

Participants *must* always be asked if they have third party insurance regardless of the TPL information given by the IVR or Internet. IT IS THE PROVIDER'S RESPONSIBILITY TO OBTAIN FROM THE PATIENT THE NAME AND ADDRESS OF THE INSURANCE COMPANY, THE POLICY NUMBER, AND THE TYPE OF COVERAGE. Reference Section 5 of this manual.

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SECTION 16 - MEDICARE/MEDICAID CROSSOVER CLAIMS

For participants having both Medicare and Medicaid eligibility, MO HealthNet pays the amounts indicated by Medicare to be deductible and/or coinsurance due on the Medicare allowed amount. These payments are referred to as “Crossovers."

Section 16, Medicare/Medicaid Crossover Claims, is *not* applicable to the following manuals:

Adult Day Care Wavier
Adult Day Health Care (Note: the Adult Day Health Care Program ends June 30, 2013)
Aged and Disabled Waiver
AIDS Waiver
Community Psychiatric Rehabilitation
Comprehensive Day Rehabilitation
CSTAR
Environmental Lead Assessment
Hospice
Independent Living Wavier
Medically Fragile Adult Wavier
MRDD Waiver
Personal Care
Private Duty Nursing

The following programs contain a modified Section 16, Medicare/Medicaid Crossover Claims

Dental
Durable Medical Equipment
Home Health
Hospital
Nursing Home
Pharmacy

END OF SECTION

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SECTION 17-CLAIMS DISPOSITION

This section of the manual provides information used to inform the provider of the status of each processed claim.

MO HealthNet claims submitted to the fiscal agent are processed through an automated claims payment system. The automated system checks many details on each claim, and each checkpoint is called an edit. If a claim *cannot* pass through an edit, it is said to have failed the edit. A claim may fail a number of edits and it then drops out of the automated system; the fiscal agent tries to resolve as many edit failures as possible. During this process, the claim is said to be suspended or still in process.

Once the fiscal agent has completed resolution of the exceptions, a claim is adjudicated to pay or deny. A statement of paid or denied claims, called a Remittance Advice (RA), is produced for the provider twice monthly. Providers receive the RA via the Internet. New and active providers wishing to download and receive their RAs via the Internet are required to sign up for Internet access. Providers may apply for Internet access at http://manuals.momed.com/Application.html. Providers are unable to access the web site without proper authorization. An authorization is required for each individual user.

17.1 ACCESS TO REMITTANCE ADVICES

Providers receive an electronic RA via the eMOMED Internet website at www.emomed.com or through an ASC X12N 835.

Accessing the RA via the Internet gives providers the ability to:

- Retrieve the RA following the weekend Financial Cycle;
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from an office desktop; and
- Download the RA into the office operating system.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the office PC and print at any convenient time.

Access to this information is restricted to users with the proper authorization. The Internet site is available 24 hours a day, 7 days a week with the exception of scheduled maintenance.

17.2 INTERNET AUTHORIZATION

If a provider uses a billing service to submit and reconcile MO HealthNet claims, proper authorization *must* be given to the billing service to allow access to the appropriate provider files.

If a provider has several billing staff who submit and reconcile MO HealthNet claims, each Internet access user *must* obtain a user ID and password. Internet access user IDs and passwords *cannot* be shared by co-workers within an office.

17.3 ON-LINE HELP

All Internet screens at www.emomed.com offer on-line help (both field and form level) relative to the current screen being viewed. The option to contact the Wipro Infocrossing Help Desk via e-mail is offered as well. As a reminder, the help desk is only responsible for the Application for MO HealthNet Internet Access Account and technical issues. The user should contact the Provider Relations Communication Unit at (573) 751-2896 for assistance on MO HealthNet Program related issues.

17.4 REMITTANCE ADVICE

The Remittance Advice (RA) shows payment or denial of MO HealthNet claims. If the claim has been denied or some other action has been taken affecting payment, the RA lists message codes explaining the denial or other action. A new or corrected claim form *must* be submitted as corrections *cannot* be made by submitting changes on the RA pages.

Claims processed for a provider are grouped by paid and denied claims and are in the following order within those groups:

Crossovers
Inpatient
Outpatient (Includes Rural Health Clinic and Hospice)
Medical
Nursing Home
Home Health
Dental
Drug
Capitation
Credits

Claims in each category are listed alphabetically by participant's last name. Each category starts on a separate RA page. If providers do *not* have claims in a category, they do *not* receive that page.

If a provider has both paid and denied claims, they are grouped separately and start on a separate page. The following lists the fields found on the RA. Not all fields may pertain to a specific provider type.

FIELD NAME	FIELD DESCRIPTION
PAGE	The remittance advice page number.
CLAIM TYPE	The type of claim(s) processed.
RUN DATE	The financial cycle date.
PROVIDER IDENTIFIER	The provider's NPI number.
RA #	The remittance advice number.
PROVIDER NAME	The name of the provider.
PROVIDER ADDR	The provider's address.
PARTICIPANT NAME	The participant's last name and first name. NOTE: If the participant's name and identification number are *not* on file, only the first two letters of the last name and the first letter of the first name appear.
MO HEALTHNET ID	The participant's current 8-digit MO HealthNet identification number.
ICN	The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim: 11— Paper Drug 13— Inpatient 14— Dental 15— Paper Medical 16— Outpatient 17— Part A Crossover 18— Paper Medicare/MO HealthNet Part B Crossover Claim 21— Nursing Home 40— Magnetic Tape Billing (MTB)—includes crossover claims sent by Medicare intermediaries. 41— Direct Electronic MO HealthNet Information (DEMI) 43— MTB/DEMI 44— Direct Electronic File Transfer (DEFT) 45— Accelerated Submission and Processing (ASAP) 46— Adjudicated Point of Service (POS) 47— Captured Point of Service (POS)

	49— Internet 50— Individual Adjustment Request 55— Mass Adjustment The third and fourth digits indicate the year the claim was received. The fifth, sixth and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from "001" (January 1) to "365" (December 31) ("366" in a leap year). The last digits of an ICN are for internal processing. For a drug claim, the last digit of the ICN indicates the line number from the Pharmacy Claim form.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number. On drug claims this field is populated with the prescription number.
CLAIM: ST	This field reflects the status of the claim. Valid values are: 1 — Processed as Primary 3 — Processed as Tertiary 4 — Denied 22 — Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount MO HealthNet paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), participant copay and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line in MMDDYY.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. NOTE: The revenue code only appears in this field if a procedure code is *not* present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. NOTE: The revenue code only appears in this field if a procedure code has also been submitted.

QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The MO HealthNet maximum allowed amount for the procedure/service.
PAID AMOUNT	The amount MO HealthNet paid on the claim.
PERF PROV	The NPI number for the performing provider submitted at the detail.
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code, which is a code identifying the general category of payment adjustment. Valid values are: CO—Contractual Obligation CR—Correction and Reversals OA—Other Adjustment PI—Payer Initiated Reductions PR—Patient Responsibility
RSN	The Claim Adjustment Reason Code, which is the code identifying the detailed reason the adjustment was made. Valid values can be found at http://www.wpc-edi.com/codes/claimadjustment.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field is *not* printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Valid values are: HE—Claim Payment Remark Codes RX—National Council for Prescription Drug Programs Reject/Payment Codes The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Valid values can be found at http://www.wpc-edi.com/codes/remittanceadvice.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.

CHECK AMOUNT	The total check amount for the provider.
EARNINGS REPORT	
PROVIDER IDENTIFIER	The provider's NPI number.
RA #	The remittance advice number.
EARNINGS DATA	
NO. OF CLAIMS PROCESSED	The total number of claims processed for the provider.
DOLLAR AMOUNT PROCESSED	The total dollar amount processed for the provider.
CHECK AMOUNT	The total check amount for the provider.

17.5 CLAIM STATUS MESSAGE CODES

Missouri no longer reports MO HealthNet-specific Explanation of Benefits (EOB) and Exception message codes on any type of remittance advice. As required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) national standards, administrative code sets Claim Adjustment Reason Codes, Remittance Advice Remark Codes and NCPDP Reject Codes for Telecommunication Standard are used.

Listings of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes can be found at http://www.wpc-edi.com/content/view/180/223/. A listing of the NCPDP Reject Codes for Telecommunication Standard can be found in the NCPDP Reject Codes For Telecommunication Standard appendix.

17.5.A FREQUENTLY REPORTED REDUCTIONS OR CUTBACKS

To aid providers in identifying the most common payment reductions or cutbacks by MO HealthNet, distinctive Claim Group Codes and Claim Adjustment Reason Codes were selected and are being reported to providers on all RA formats when the following claim payment reduction or cutback occurs:

Claim Payment Reduction/Cutback	Claim Group Code	Description	Claim Adjustment Reason Code	Description
Payment reimbursed at the maximum allowed	CO	Contractual Obligation	45	Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.
Payment reduced by	OA	Other	23	Payment adjusted because

other insurance amount		Adjustment		charges have been paid by another payer
Medicare Part A Repricing	OA	Other Adjustment	45	Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.
Payment cut back to federal percentage (IEP therapy services)	OA	Other Adjustment	A2	Contractual adjustment
Payment reduced by co-payment amount	PR	Patient Responsibility	3	Co-Payment amount
Payment reduced by patient spenddown amount	PR	Patient Responsibility	178	Payment adjusted because patient has *not* met the required spenddown
Payment reduced by patient liability amount	PR	Patient Responsibility	142	Claim adjusted by monthly MO HealthNet patient liability amount

17.6 SPLIT CLAIM

An ASC X12N 837 electronic claim submitted to MO HealthNet may, due to the adjudication system requirements, have service lines separated from the original claim. This is commonly referred to as a split claim. Each portion of a claim that has been split is assigned a separate claim internal control number and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge. Currently, within MO HealthNet's MMIS, a maximum of 28 service lines per claim are processed. The 837 Implementation Guides allow providers to bill a greater number of service detail lines per claim.

All detail lines that exceed the size allowed in the internal MMIS detail record are split into subsequent detail lines. Any claim that then exceeds the number of detail lines allowed on the internal MMIS claim record is used to create an additional claim.

17.7 ADJUSTED CLAIMS

Adjustments are processed when the original claim was paid incorrectly and an adjustment request is submitted.

The RA will show a credit (negative payment) ICN for the incorrect amount and a payment ICN for the correct amount.

If a payment should *not* have been made at all, there will not be a corrected payment ICN.

17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED)

Suspended claims are *not* listed on the Remittance Advice (RA). To inquire on the status of a submitted claim *not* appearing on the RA, providers may either submit a 276 Health Care Claim Status Request or may submit a View Claim Status query using the Real Time Queries function online at www.emomed.com. The suspended claims are shown as either paid or denied on future RAs without any further action by the provider.

17.9 CLAIM ATTACHMENT STATUS

Claim attachment status is not listed on the Remittance Advice (RA). Providers may check the status of six different claim attachments using the Real Time Queries function on-line at www.emomed.com. Claim attachment status queries are restricted to the provider who submitted the attachment. Providers may view the status for the following claim attachments on-line:

- Acknowledgement of Receipt of Hysterectomy Information
- Certificate of Medical Necessity (for Durable Medical Equipment only)
- Medical Referral Form of Restricted Participant (PI-118)
- Oxygen and Respiratory Equipment Medical Justification Form (OREMJ)
- Second Surgical Opinion Form
- (Sterilization) Consent Form

Providers may use one or more of the following selection criteria to search for the status of a claim attachment on-line:

- Attachment Type
- Participant ID
- Date of Service/Certification Date
- Procedure Code/Modifiers
- Attachment Status

Detailed Help Screens have been developed to assist providers searching for claim attachment status on-line. If technical assistance is required, providers are instructed to call the Wipro Infocrossing Help Desk at (573) 635-3559.

17.10 PRIOR AUTHORIZATION STATUS

Providers may check the status of Prior Authorization (PA) Requests using the Real Time Queries function on-line at www.emomed.com. PA status queries are restricted to the provider who submitted the Prior Authorization Request.

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SECTION 18—DIAGNOSIS CODES

18.1 GENERAL INFORMATION

The diagnosis code is a required field and the accuracy of the code that describes the participant's condition is important.

The diagnosis code *must* be entered on the claim exactly as it appears in the applicable ICD-CM. Note that the appropriate code(s) may be three, four or five digits, depending upon the participant's diagnosis. The fourth and fifth digits give greater detail or specificity, and *must* be used as applicable to the participant's diagnosis(es) when available.

Diagnosis codes are *not* included in this section. Claims may be denied if a three digit code is used. The applicable ICD-CM may require a fourth or fifth digit. The applicable ICD-CM (Volume I) should be used as a guide in the selection of the appropriate three, four or five digit diagnosis code. The applicable ICD-CM may be purchased in softbound or binder. The binder contains all three volumes, which are:

Volume 1: Diseases: Tabular List
Volume 2: Diseases: Alphabetic Index
Volume 3: Procedures: Tabular List and Alphabetic Index

Additional information regarding the applicable ICD-CM may be found at www.cdc.gov/nchs/icd.htm.

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SECTION 19 –PROCEDURE CODES

Procedure codes used by MO HealthNet are identified as HCPCS codes (Health Care Procedure Coding System). The HCPCS is divided into three subsystems, referred to as level I, level II and level III. Level I is comprised of Current Procedural Terminology (CPT) codes that are used to identify medical services and procedures furnished by physicians and other health care professionals. Level II is comprised of the HCPCS National Level II codes that are used primarily to identify products, supplies and services *not* included in the CPT codes. Level III codes have been developed by Medicaid State agencies for use in specific programs. NOTE: Replacement of level III codes is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Providers should reference bulletins for code replacement information.

Reference materials regarding the HealthCare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) may be obtained through the American Medical Association at:

Order Department
American Medical Association
P.O. Box 930876
Atlanta, GA 31193-0876
Telephone Number: (800) 621-8335
AMA Members (312) 262-3211
Fax Orders: (312) 464-5600
https://catalog.ama-assn.org/Catalog/home.jsp

19.1 PROCEDURE CODES

This section lists the appropriate procedure codes for the billing of personal care services. The only acceptable place of service (POS) is 12, for home. The licensed Residential Care Facility (RCF)/Assisted Living Facility (ALF) is considered the participant's home for the purpose of providing MO HealthNet personal care; therefore, the POS code for services delivered in an RCF/ALF is also 12. The procedure codes listed in this section are effective for services provided on or after 10/1/03.

19.1.A SERVICES AUTHORIZED BY THE DIVISION OF SENIOR AND DISABILITY SERVICES

PROC CODE	DESCRIPTION	SERVICE UNIT
T1019	Personal Care	15-min unit
T1001	Authorized Nurse Visit	per visit

T1019TF	Advanced Personal Care	15-min. unit
T1019U3	Personal Care in RCF/ALF	15-min. unit
T1019U3TF	Advanced Personal Care in RCF/ALF	15-min. unit
T1001U3	Authorized Nurse Visit in RCF/ALF	per visit
T1028TS	Participant Reassessments	One per year*

*Reassessments are done by the provider upon notification of a list provided by DSDS

19.1.B SERVICES FOR CHILDREN, AUTHORIZED BY THE DEPARTMENT OF HEALTH AND SENIOR SERVICES, BUREAU OF SPECIAL HEALTH CARE NEEDS

The following codes are valid only for MO HealthNet participants aged 0-20, for services under the Healthy Children and Youth Program (HCY).

PROC CODE	DESCRIPTION	SERVICE UNIT
T1019EP	Personal Care	15-min. unit
T1019TFEP	Advanced Personal Care	15-min. unit
T1001EP	Authorized Nurse Visit	per visit

THE FOLLOWING CODE REQUIRES NO PRIOR AUTHORIZATION AND IS RESTRICTED TO PARTICIPANTS UNDER THE AGE OF 21. TWO VISITS MAY BE BILLED PER PARTICIPANT, PER AGENCY, PER ROLLING YEAR.

PROC CODE	DESCRIPTION	SERVICE UNIT
T1001TDEP	R.N. Evaluation Visit for Personal Care through Healthy Children and Youth	per visit

A rolling year is client specific. For example, if a client's first date of service is April 15, 2012, then two evaluation visits could be billed between April 15, 2012 and April 14, 2013 by one provider.

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SECTION 20 - EXCEPTION PROCESS

The Exception Process is a formal process under which the MO HealthNet Division may grant an exception and authorize an essential medical service or item of equipment that otherwise exceeds the benefits and limitations set in policy.

Section 20, Exception Process, is *not* applicable to the following manuals, because services *cannot* be approved in accordance with the exception process regulation.

Adult Day Health Care
Aged and Disabled Waiver
AIDS Waiver
Ambulance
Community Psychiatric Rehabilitation
Comprehensive Day Rehabilitation
CSTAR
Environmental Lead Assessment
Hearing Aid
Hospice
MRDD Waiver
Nurse Midwife
Optical
Personal Care
Private Duty Nursing
Psychology/Counseling
Therapy

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SECTION 21- ADVANCE HEALTH CARE DIRECTIVES

This section describes the responsibility of certain providers to inform adult participants of their rights under state law to make medical care decisions and the right to make an advanced health care directive.

Section 21, Advance Health Care Directives, is *not* applicable to the following manuals:

Adult Day Health Care
Aged and Disabled Waiver
Ambulance
Ambulatory Surgical Centers
Community Psychiatric Rehabilitation
Comprehensive Day Rehabilitation
CSTAR
Dental
Durable Medical Equipment
Environmental Lead Assessment
Hearing Aid
ID/DD Waiver
Nurse Midwife
Optical
Pharmacy
Private Duty Nursing
Psychology/Counseling
Rehabilitation Centers
Therapy

END OF SECTION

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SECTION 22-NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

22.1 INTRODUCTION

This section contains information pertaining to the Non-Emergency Medical Transportation's (NEMT) direct service program. The NEMT Program provides for the arrangement of transportation and ancillary services by a transportation broker. The broker may provide NEMT services either through direct service by the broker and/or through subcontracts between the broker and subcontractor(s).

The purpose of the NEMT Program is to assure transportation to MO HealthNet participants who do *not* have access to free appropriate transportation to and from scheduled MO HealthNet covered services.

The Missouri NEMT Program is structured to utilize and build on the existing transportation network in the state. The federally-approved method used by Missouri to structure the NEMT Program allows the state to have one statewide transportation broker to coordinate the transportation providers. The broker determines which transportation provider will be assigned to provide each transport.

22.2 DEFINITIONS

The following definitions apply for this program:

Action	The denial, termination, suspension, or reduction of an NEMT service.
Ancillary Services	Meals and lodging are part of the transportation package for participants, when the participant requires a particular medical service which is only available in another city, county, or state and the distance and travel time warrants staying in that place overnight. For children under the age of 21, ancillary services may include an attendant and/or one parent/guardian to accompany the child.
Appeal	The mechanism which allows the right to appeal actions of the broker to a transportation provider who as (1) has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness; or (2) is aggrieved by an rule or policy or procedure or decision by the broker.
Attendant	An individual who goes with a participant under the age of 21 to the MO HealthNet covered service to assist the participant because the participant

	cannot travel alone or *cannot* travel a long distance without assistance. An attendant is an employee of, or hired by, the broker or an NEMT transportation provider.
Basic/Urban/ Rural Counties	As defined in 20 CSR, the following counties are categorized as: • Urban – Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City; • Basic – Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney; • Rural – All other counties.
Broker	Contracted entity responsible for enrolling and paying transportation providers, determining the least expensive and most appropriate type of transportation, authorizing transportation and ancillary services, and arranging and scheduling transportation for eligible participants to MO HealthNet covered services.
Call Abandonment	Total number of all calls which disconnect prior to reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.
Call Wait Time	Total amount of time after a call is received into the queue until reaching a live voice for all incoming lines for callers to make reservations, trip inquiries or file complaints.
Clean Claim	A claim that can be processed without obtaining additional information from the transportation provider of the NEMT service or from a third party.
Complaint	A verbal or written expression by a transportation provider which indicates dissatisfaction or dispute with a participant, broker policies and procedures, claims, or any aspect of broker functions.
DCN	Departmental Client Number. A unique eight-digit number assigned to each individual who applies for MO HealthNet benefits. The DCN is also known as the MO HealthNet Identification Number.
Denial Reason	The category utilized to report the reason a participant is not authorized for transportation. The denial categories are: • Non-covered Service

- Lack of Day's Notice
- Participant Ineligible
- Exceeds Travel Standards
- Urgency Not Verified by Medical Provider
- Participant has Other Coverage
- No Vehicle Available
- Access to Vehicle
- Not Closest Provider
- MHD Denied: Over Trip Leg Limit
- Access to Free Transportation
- Not Medicaid Enrolled Provider
- Incomplete Information
- Refused Appropriate Mode
- Minor Without Accompaniment
- Participant Outside Service Area

Emergency

An emergency medical condition for a MO HealthNet participant means a medical or a behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (a) that there is inadequate time to affect a safe transfer to another hospital before delivery or; (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Post stabilization care services mean covered services, related to an emergency medical condition, that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

Fraud

Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some

	unauthorized benefit to the entity, himself/herself, or some other person.
Free Transportation	Any appropriate mode of transportation that can be secured by the participant without cost or charge, either through volunteers, organizations/associations, relatives, friends, or neighbors.
Grievance (Participant)	A verbal or written expression of dissatisfaction from the participant about any matter, other than an action. Possible subjects for grievances include, but are *not* limited to, the quality of care or services received, condition of mode of transportation, aspects of interpersonal relationships such as rudeness of a transportation provider or broker's personnel, or failure to respect the participant's rights.
Grievance (Transportation Provider)	A written request for further review of a transportation provider's complaint that remains unresolved after completion of the complaint process.
Inquiry	A request from a transportation provider regarding information that would clarify broker's policies and procedures, or any aspect of broker function that may be in question.
Most Appropriate	The mode of transportation that accommodates the participant's physical, mental, or medical condition.
MO HealthNet Covered Services	Covered services under the MO HealthNet program.
Medically Necessary	Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could *not* have been omitted without adversely affecting the participant's condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services *must* be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.
Medical Service Provider	An individual firm, corporation, hospital, nursing facility, or association that is enrolled in MO HealthNet as a participating provider of service, or MO HealthNet services provided free of charge by the Veterans

	Administration or Shriners Hospital.
NEMT Services	Non-Emergency Medical Transportation (NEMT) services are a ride, or reimbursement for a ride, and ancillary services provided so that a MO HealthNet participant with no other transportation resources can receive MO HealthNet covered services from a medical service provider. By definition, NEMT does *not* include transportation provided on an emergency basis, such as trips to the emergency room in life-threatening situations, unloaded miles, or transportation provider wait times.
No Vehicle Available	Any trip the broker does not assign to a transportation provider due to inability or unwillingness of the transportation provider to accommodate the trip. All "no vehicle available" trips shall be reported as denials in the category of no vehicle available.
Participant	A person determined by the Department of Social Services, Family Support Division (FSD) to be eligible for a MO HealthNet category of assistance.
Pick-up Time	The actual time the participant boarded the vehicle for transport. Pick up time must be documented for all trips and must be no later than 5 minutes from the scheduled pick-up time. Trips completed or cancelled due to transportation provider being late must be included in the pick-up time reporting.
Public Entity	State, county, city, regional, non-profit agencies, and any other entity, who receive state general revenue or other local monies for transportation and enter into an interagency agreement with the MO HealthNet Division to provide transportation to a specific group of eligibles.
Transportation Leg	From pick up point to destination.
Transportation Provider	Any individual, including volunteer drivers, or entity who, through arrangement or subcontract with the broker, provides non-emergency medical transportation services. Transportation providers are not enrolled as MO HealthNet providers.
Urgent	A serious, but *not* life threatening illness/injury. Examples include, but are *not* limited to, high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do *not* require emergency room services, and persistent rash. The broker shall arrange urgent trips, as deemed urgent and requested by the participant or the participant's medical provider.

Will Call	An unscheduled pick-up time when the participant calls the broker or transportation provider directly for a return trip. Transportation shall pick-up participant within 60 minutes of the participants call requesting return trip.

22.3 COVERED SERVICES

The broker shall ensure the provision of Non-Emergency Medical Transportation (NEMT) services for participants to MO HealthNet covered services for the Department of Social Services, MO HealthNet Division. The broker *must* ensure that NEMT services are available 24 hours per day, 7 days per week, when medically necessary. To provide adequate time for NEMT services to be arranged, a participant should call at least two (2) business days in advance when they live within an urban county and at least three (3) business days advance notice if they live in the a rural or basic county, with the exception of an urgent care or hospital discharge.

NEMT services may be scheduled with less than the required days' notice if they are of an urgent nature. Urgent calls are defined as a serious, but *not* life threatening illness/injury. Urgent trips may be requested by the participant or participant's medical provider. The number for scheduling transportation is (866) 269-5927. This number is accessible 24 hours a day, 7 days a week. Non-urgent trips can be scheduled Monday thru Friday, 8:00 am-5:00 pm.

The broker shall provide NEMT services to MO HealthNet covered services that do *not* include transportation. In addition, the broker *must* arrange NEMT services for one parent/guardian to accompany children under the age of 21, if requested. The broker *must* also arrange NEMT services for an attendant, if appropriate, to accompany children under the age of 21. If the participant is under the age of 17, a parent/guardian must ride with them.

In addition to authorizing the transportation services, the broker shall authorize and arrange the least expensive and most appropriate ancillary services. Ancillary services shall only be authorized if:

1. The medical appointment requires an overnight stay, AND
2. Volunteer, community, or other ancillary services are *not* available at no charge to the participant.

The broker shall also authorize and arrange ancillary services for one parent/guardian when a MO HealthNet eligible child is inpatient in a hospital setting and meets the following criteria:

1. Hospital does not provide ancillary services without cost to the participant's parent/guardian, AND
2. Hospital is more than 120 miles from the participant's residence, OR
3. Hospitalization is related to a MO HealthNet covered transplant service.

The broker shall obtain prior authorization from the state agency for out-of-state transportation to non-bordering states.

If the participant meets the criteria specified above, the broker shall also authorize and arrange ancillary services to eligible participants who have access to transportation at no charge to the participant or receive transportation from a Public Entity and such ancillary services were not included as part of the transportation service.

The broker shall direct or transfer participants with requests that are of an emergent nature to 911 or an appropriate emergency (ambulance) service.

22.4 PARTICIPANT ELIGIBILITY

The participant *must* be eligible for MO HealthNet to receive transportation services.

The broker shall verify whether the individual seeking NEMT services is eligible for NEMT services on the date of transport by accessing eligibility information. Information regarding participant eligibility may be found in Section 1 of this manual.

22.5 NON-COVERED PARTICIPANTS

The following participants are *not* eligible for NEMT services provided by the broker:

1. Participants with the following MO HealthNet Eligibility (ME) codes: 02, 08, 52, 55, 57, 59, 64, 65, 73, 74, 75, 80, 82, 89, 91, 92, 93, and 97.
2. Participants who have access to transportation at no cost to the participant. However, such participants may be eligible for ancillary services.
3. Participants who have access to transportation through a Public Entity. However, such participants may be eligible for ancillary services.
4. Participants who have access to NEMT through the Medicare program.
5. Participants enrolled in the Hospice Program. However, the broker shall arrange NEMT services for such participants accessing MO HealthNet covered services that are *not* related to the participant's terminal illness.
6. Participants in a MO HealthNet managed care health plan.
    a. NEMT services for participants enrolled in MO HealthNet Managed Care Health Plans is arranged by those programs for services included in the benefit package. The broker shall *not* be responsible for arranging NEMT services for the health plans.

22.6 TRAVEL STANDARDS

The participant *must* request NEMT services to a MO HealthNet qualified; enrolled medical service provider located within the travel standards, willing to accept the participant. The travel standards are based on the participant's county of residence. Counties are classified as urban, basic, and rural. The counties are categorized as follows:

1. Urban-Clay, Greene, Jackson, Jefferson, St. Charles, St. Louis, and St. Louis City;
2. Basic-Boone, Buchanan, Cape Girardeau, Cass, Christian, Cole, Franklin, Jasper, Johnson, Lincoln, Newton, Platte, Pulaski, St. Francois and Taney;
3. Rural-all other counties.

The mileage that a participant can travel is based on the county classification and the type of provider being seen. The following table contains the mileage allowed under the travel standards.

TRAVEL STANDARDS: MAXIMUM MILEAGE

Provider/Service Type	**Urban Access County**	**Basic Access County**	**Rural Access County**
Physicians			
PCPs	10	20	30
Obstetrics/Gynecology	15	30	60
Neurology	25	50	100
Dermatology	25	50	100
Physical Medicine/Rehab	25	50	100
Podiatry	25	50	100
Vision Care/Primary Eye Care	15	30	60
Allergy	25	50	100
Cardiology	25	50	100
Endocrinology	25	50	100
Gastroenterology	25	50	100
Hematology/Oncology	25	50	100

Infectious Disease	25	50	100
Nephrology	25	50	100
Ophthalmology	25	50	100
Orthopedics	25	50	100
Otolaryngology	25	50	100
Pediatric	25	50	100
Pulmonary Disease	25	50	100
Rheumatology	25	50	100
Urology	25	50	100
General surgery	15	30	60
Psychiatrist-Adult/General	15	40	80
Psychiatrist-Child/Adolescent	22	45	90
Psychologists/Other Therapists	10	20	40
Chiropractor	15	30	60
Hospitals			
Basic Hospital	30	30	30
Secondary Hospital	50	50	50
Tertiary Services			
Level I or Level II trauma unit	100	100	100
Neonatal intensive care unit	100	100	100
Perinatology services	100	100	100
Comprehensive cancer services	100	100	100
Comprehensive cardiac services	100	100	100
Pediatric subspecialty care	100	100	100

Mental Health Facilities			
Inpatient mental health treatment facility	25	40	75
Ambulatory mental health treatment providers	15	25	45
Residential mental health treatment providers	20	30	50
Ancillary Services			
Physical Therapy	30	30	30
Occupational Therapy	30	30	30
Speech Therapy	50	50	50
Audiology	50	50	50

The broker *must* transport the participant when the participant has chosen a qualified, enrolled medical service provider who is *not* within the travel standards if the participant is eligible for one of the exceptions listed below and can provide proof of the exception:

1. The participant has a previous history of other than routine medical care with the qualified, enrolled medical service provider for a special condition or illness.
2. The participant has been referred by a Primary Care Provider (PCP) to a qualified, enrolled medical service provider for a special condition or illness.
3. There is *not* a routine or specialty care appointment available within thirty (30) calendar days to a qualified, enrolled medical service provider within the travel standards.

The broker shall transport the participant to the following MO HealthNet services without regard to the travel standards.

1. The participant is scheduled for an appointment arranged by the Family Support Division (FSD) eligibility specialist for a Medical Review Determination (MRD) to determine continued MO HealthNet eligibility.
2. The participant has been locked into a medical service provider by the state agency. The broker shall receive prior authorization from the state agency for lock-in trips that exceed the travel standards.
3. The broker must transport the participant when the participant has chosen to receive MO HealthNet covered services free of charge from the Veterans Administration or Shriners Hospitals. Transportation to the Veterans Administration or Shriners Hospital must be to the closest, most appropriate Veterans Administration or Shriners Hospital. The broker must document and maintain verification of service for each transport provided to free care.

The broker must verify each request of such transport meets all NEMT criteria including, but not limited to:

- Participant eligibility; and
- MO HealthNet covered service.

22.7 COPAYMENTS

The MO HealthNet Division (MHD) does not require copayments for any services at this time. Providers will be notified when copayments are reinstated.

22.8 MODES OF TRANSPORTATION

The broker *must* arrange the least expensive and most appropriate mode of transportation based on the participant's medical needs. The modes of transportation that may be utilized by the broker include, but are *not* limited to:

1. Public transit/bus tokens;
2. Gas reimbursement;
3. Para-lift van;
4. Taxi or rideshare service;
5. Ambulance (for non-emergent transportation only);
6. Stretcher van;
7. Multi-passenger van; and
8. Volunteer driver program if approved by the state agency.

The broker *must not* utilize public transit/bus token/pass for the following situations:

1. High-risk pregnancy;
2. Pregnancy after the eighth month;
3. High risk cardiac conditions;
4. Severe breathing problems;
5. More than three (3) block walk or more than one-quarter (1/4) of a mile, whichever is the least amount of distance, to the bus stop; and
6. Any other circumstance in which utilization of public transit/bus token/pass may not be medically appropriate.

Prior to reimbursing a participant for gas, the broker shall verify that the participant actually saw a medical service provider on the date of request for gas reimbursement and verify the mileage from

the participant's trip origin street address to the trip destination street address. If the street address is not available, the broker shall use the zip code for mileage verification. Gas reimbursement shall be made at the IRS standard mileage rate for medical reason in effect on the date of service.

The broker shall limit the participant to no more than three (3) transportation legs (2 stops) per day unless the broker received prior authorization from the state agency.

The broker shall ensure that the transportation provided to the participant is comparable to transportation resources available to the general public (e.g. buses, taxis, etc.).

22.9 LEVEL OF SERVICE

The type of vehicle needed is determined by the level of service (LOS) required. Please note that ModivCare (formerly LogistiCare) provides shared transportation, so participants should expect to share their ride with other participants (excluding stretcher services). Levels of service include:

1. Ambulatory includes those using a manual wheelchair who can stand or pivot on their own. This may include the use of public transportation and/or taxis.
2. Wheelchair those participants who have an electric wheelchair or a manual wheelchair but cannot transfer.
3. Stretcher Service those participants confined to a bed. Please refer to the Stretcher Assessment Form.
4. Non-emergency Ambulance participants need equipment only available on an ambulance (i.e. non-portable oxygen) or when travel by other means could be detrimental to the participant's health (i.e. body cast).

The Facility Service Worker or Case Manager can assist ModivCare (formerly LogistiCare) by providing the necessary information to determine the LOS and by keeping this information updated on the Standing Orders (SOs).

22.10 ARRANGING TRANSPORTATION

When calling to arrange for transport, the caller *must* provide the following information:

- The patient/participant's name, date of birth, address, phone number, and the MO HealthNet ID number;
- The name, address, and phone number of the medical provider that will be seen by the participant;
- The date and time of the medical appointment;

- Any special transportation needs of the patient/participant, such as the patient/participant uses a wheelchair;
- Whether the patient/participant is under 21 years of age and needs someone to go along to the appointment; and
- For facilities arranging transportation for your dialysis participants, please refer to Section 22.17 of this manual.

22.11 NON-COVERED SERVICES

The following services are *not* eligible for NEMT:

1. The broker shall *not* provide NEMT services to a pharmacy except when a participant has an appointment to receive a vaccination.
2. Transportation to services included in the Intellectually Disabled/Developmentally Disabled (ID/DD) Waiver Programs, Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation Program, and Department of Health and Senior Services Waiver Programs are arranged by those programs. Community psychiatric rehabilitation program only provides transportation to attend the psychosocial rehabilitation services and to receive medication services. The broker shall *not* be responsible for arranging NEMT services for these programs or services. However, the broker shall arrange NEMT services for the participants to other qualified, enrolled medical service providers such as physician, outpatient hospital, lab, etc.
3. School districts *must* supply a ride to services covered in a child's Individual Education Plan (IEP).
4. The broker shall *not* arrange NEMT services to a Durable Medical Equipment (DME) provider that provides free delivery or mail order services. The broker shall *not* provide delivery of DME products in lieu of transporting the participant.
5. The broker shall *not* provide NEMT services for MO HealthNet covered services provided in the home such as personal care, home health, etc.
6. The broker shall *not* provide NEMT services for discharges from a nursing home.
7. The broker shall *not* authorize nor arrange NEMT services to case management services.

22.12 PUBLIC ENTITY REQUIREMENTS

The state agency has existing interagency agreements with public entities to provide access (subject to availability) to transportation services for a specific group(s) of participants. The broker shall refer participants to public entities when the participant qualifies for transportation services under such

agreements. The following is a list of the public entities and the specific individuals for which transportation is covered:

1. **Children's Division (CD)** CD provides reimbursement for transportation services to MO HealthNet covered services for some children. Eligible individuals are identified by the CD.
2. **School-based NEMT Services** Some school districts provide transportation for children to obtain medically necessary services provided as a result of a child's Individual Education Plan (IEP). Eligible children are identified by the school district.
3. **KCATA/RideKC Connection** KCATA provides door-to-door accessible transportation to persons with disabilities and the elderly. Services are available to residents of Kansas City, Missouri. Individuals *must* complete an application and be approved to participate in the program.
4. **Bi-State Development Agency DBA Metro Transit** Metro Transit provides curb-to-curb accessible transportation to persons with disabilities and the elderly who reside in St. Louis City and County.
5. **City Utilities of Springfield, Transit** City Utilities operates a para-transit service to serve disabled who are unable to ride a fixed route bus. This service is operated on a demand-responsive curb to curb basis. A one-day notice is required for reservations.
6. **City of Jefferson/Jefftran** Jefftran is a curb-to-curb, origin to destination transportation service with wheelchair, lift-equipped buses. Jefftran is provided to all eligible individuals with disability without priority given for trip purpose. Jefftran is intended to be used by individuals who, because of disability, *cannot* travel to or from a regular fixed route bus stop or *cannot* get on, ride, or get off a regular fixed route bus *not* wheelchair lift-equipped. This service operates to and from any location within Jefferson City.
7. **Nevada City Hospital** Nevada City Hospital transports individuals who live within a 20 mile radius of Nevada.
8. **Columbia Transit** Columbia Transit transports individuals with disabilities within the Columbia City Limits. This service provides buses on peak hours including para-transit curb to curb services.

22.13 PROVIDER REQUIREMENTS

The broker shall maintain a network of appropriate transportation providers that is sufficient to provide adequate access to all MO HealthNet covered services. In establishing and maintaining the network, the broker *must* consider the following:

1. The anticipated MO HealthNet enrollment;

2. The expected utilization of services taking into consideration the characteristics and health care needs of MO HealthNet populations;
3. The numbers and types (in terms of training, experience, and specialization) of transportation providers required to furnish services;
4. The capacity of transportation providers to provide services; and
5. If the broker is unable to provide necessary NEMT services to a particular participant utilizing the services of an in-network transportation provider, the broker *must* adequately and timely provide the NEMT services for the participant utilizing the services of a transportation provider outside the broker's network, for as long as the broker is unable to provide such NEMT services utilizing an in-network transportation provider. Out-of-network transportation providers *must* coordinate with the broker with respect to payment. The broker *must* ensure that cost to the participant is no greater than it would be if the NEMT services were furnished utilizing the services of an in-network transportation provider.

The broker and all transportation providers shall comply with applicable city, county, state, and federal requirements regarding licensing and certification of all personnel and vehicles.

The broker shall ensure the safety of the participants while being transported. The broker shall ensure that the vehicles operated by the transportation providers are in compliance with federal motor vehicle safety standards (49 Code of Federal Regulations Part 571). This provision does *not* apply when the broker provides direct reimbursement for gas.

The broker shall maintain evidence of providers' non-compliance or deficiencies, as identified either through individual reports or as a result of monitoring activities, the corrective action taken, and improvements made by the provider.

The broker shall *not* utilize any person as a driver or attendant whose name, when checked against the Family Care Safety Registry, registers a "hit" on any list maintained and checked by the registry.

22.14 PROVIDER INQUIRY, COMPLAINT, GRIEVANCE AND APPEAL PROCESS

All transportation provider inquiries, complaints, grievances and appeals as defined under 'Definition', *must* be filed with the NEMT broker. The broker *must* resolve all complaints, grievances and appeals in a timely manner. The transportation provider will be notified in writing of the outcome of each complaint, grievance and appeal.

In order to inquire about a broker policy or procedure or to file a complaint, grievance or appeal, contact the broker at the following address or telephone number:

ModivCare (formerly LogistiCare)
13690 Riverport Drive
Suite210
Maryland Heights, MO 63043
866-269-5944

22.15 PARTICIPANT RIGHTS

Participants *must* be given the rights listed below:

1. General rule. The broker *must* comply with any applicable federal and state laws that pertain to participant rights and ensure that the broker's personnel and transportation providers take those rights into account when furnishing services to participants.
2. Dignity and privacy. Each participant is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
3. Copy of transportation records. Each participant is guaranteed the right to request and receive a copy of his or her transportation records.
4. Free exercise of rights. Each participant is free to exercise his or her rights, and that the exercise of those rights does *not* adversely affect the way the broker and the broker's transportation providers or the state agency treat the participant.

22.16 DENIALS

The broker shall make a decision to arrange for NEMT services within 24 hours of the request. If the broker denies the request for services, the broker shall provide written notification to the participant. The notice *must* indicate that the broker has denied the services, the reasons for the denial, the participant's right to request a State fair hearing, and how to request a State fair hearing. The broker shall review all denials for appropriateness and provide prior verbal notification of the denial in addition to written notification.

The state agency shall maintain an independent State fair hearing process as required by federal law and regulation, as amended. The State fair hearing process shall provide participants an opportunity for a State fair hearing before an impartial hearing officer. The parties to the state fair hearing include the broker as well as the participant and his or her representative or the representative of a deceased participant's estate.

22.17 PARTICIPANT GRIEVANCE PROCESS

If a participant is unhappy with the services that NEMT provides, a grievance can be filed. The broker thoroughly investigates each grievance and shall acknowledge receipt of each grievance in

writing within ten business days after receiving the grievance. The number to call is (866) 269-5944. Written grievances can be sent to:

ModivCare (formerly LogistiCare)
13690 Riverport Drive
Suite 210
Maryland Heights, MO 63043

22.18 STANDING ORDERS

Authorized clinicians (i.e., FSW, CM, or RN) at a treatment facility may request a ModivCare (formerly LogistiCare) facility representative to enter a SO for ongoing NEMT services for their MO HealthNet participants who are required to attend a covered appointment for at least three days per week for a period of at least 90 days or greater.

1. The following is the process for coordinating SOs:
2. The MO HealthNet participant's social worker or other medical professional at the treating facility faxes the Standing Order Form for Regularly Scheduled Appointments to the ModivCare (formerly LogistiCare) facility department at 1-866-269-5944. The facility representative reviews the information to ensure the requested SO meets the criteria as discussed above and enters the treatment times and dates as a SO.
3. The facility representative returns the SO by fax or calls the requesting clinician as confirmation that the SO has been received and entered. The facility representative also calls the requesting clinician if the transportation request does not meet the criteria for a SO.
4. FSWs or CMs are required to report any change to the SO (i.e. death, transplant, address, time, LOS or facility) as soon as they are aware of the change. The information is faxed to 1-866-269-8875. Upon notification, ModivCare (formerly LogistiCare) will inactivate SOs for participants who are hospitalized. When the participant is discharged from the hospital and is ready to resume transportation, a new SO will need to be faxed to ModivCare (formerly LogistiCare).
5. All SOs are required to be recertified every 90 days. The facility representative calls to confirm all SOs as a requirement of our Utilization Review protocol. Facilities are sent a monthly Standing Order Trip Verification Report and Standing Order Report by the 5th day of every month, with each participant's name and MO HealthNet number. These reports allow the clinician to make changes to existing SOs and also inform ModivCare (formerly LogistiCare) of any days, in the prior month, the MO HealthNet participant did not attend a scheduled treatment. FSWs or CMs are encouraged to respond promptly to the reports to continue to assure appropriate confirmation and verification of trips.

6. The Dialysis Mileage Reimbursement Log & Invoice Form is sent, upon request, to participants who wish to provide their own transportation. The FSW also has copies or can request copies of this form. Participants complete the form and have it signed by a facility clinician. The participant then sends the form to ModivCare (formerly LogistiCare) so that it is received within 45 days of the appointment.

22.19 ANCILLARY SERVICES

A medical provider may request ancillary services (meals and lodging) for adults and children and one parent/guardian, if necessary to accompany the child, if: 1) the medical appointment requires an overnight stay; and, 2) volunteer, community or other ancillary services are not available free of charge to the participant. (Note: due to the Free Care Rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.) For further information regarding Ancillary Services, please refer to Section 22.17.E(1) of this manual and the Ancillary Services Form.

22.19.A ANCILLARY SERVICES REQUEST PROCEDURE

A medical provider may request ancillary services for adults and children with one parent/guardian to accompany the child, if:

1. The medical appointment requires an overnight stay, and
2. Volunteer, community, or other ancillary services are not available at no charge to the participant. (Note: due to the free care rule, if services are available to any non-MO HealthNet family at no cost, a MO HealthNet family may not be charged for the services.)

Non-emergency medical transportation services are tied to a MO HealthNet covered medical appointments/services for a MO HealthNet participant. Lodging is provided only when the participant is staying in the room. Meals are available for both the participant and one parent or guardian when he/she is traveling with a child to the medical appointment that requires an overnight stay.

The following is the process in which Ancillary Services will be coordinated:

1. The request for Ancillary Services Form is to be faxed to the ModivCare (formerly LogistiCare) Facility Department at 1-866-269-8875 by the participant's case manager, social worker, or a medical professional.
2. A ModivCare (formerly LogistiCare) Facility Representative will contact a non-profit housing facility (i.e. Ronald McDonald House) prior to contacting hotels, as this would be the least expensive accommodation if one is available within the hospital's geographic area. Should a room not

be available, ModivCare (formerly LogistiCare) will arrange the least expensive, most appropriate hotel accommodation. The hotel will be paid directly by ModivCare (formerly LogistiCare).

3. ModivCare (formerly LogistiCare) will provide two (2) meals per day, per child and one parent/guardian. Most hotels provide a continental breakfast for their guests.
4. If a meal ticket can be provided by the hospital, the hospital will, in turn, invoice ModivCare (formerly LogistiCare) along with a copy of the ModivCare (formerly LogistiCare) Authorized Ancillary Services Form for the meals to ModivCare (formerly LogistiCare) MO NEMT Billing, 2552 West Erie Drive, Suite 101, Tempe, AZ 85282.
5. If a hospital is unable to provide meal tickets, the parent/guardian will need to submit the original receipts for reimbursement to the ModivCare (formerly LogistiCare) Facility Department, 13690 Riverport Drive, Suite 210, Maryland Heights, MO 63043. They must reference the job number and date of service on the receipt for reimbursement. The job number or confirmation number is found on the authorization form faxed to the requesting facility.
6. Should the participant's family request gas reimbursement, a Gas Reimbursement Voucher will be sent to the parent/guardian for submission of gas expenses. Unlike dialysis gas reimbursement that allows 45 days for submission, this form must be submitted within 30 days of the actual trip.
7. The confirmation number (job number) along with the hotel name and address will be entered on the Ancillary Services Form and the form will be signed authorizing the services. The form will be faxed back to the requesting facility.

22.20 WHERE'S MY RIDE? (WMR)

All facilities are provided with the WMR contact information located on the Missouri Contact Information Sheet which is included in the information packets. The WMR line is 1-866-269-5944.

Facilities are encouraged to have these numbers available for participants.

1. The Transportation Provider (TP) is allowed a grace period of 15 minutes past the SO appointment and pickup time. If a TP is more than 15 minutes late for a SO appointment or pick-up time, FSWs, participants, or any facility designee are encouraged to call the WMR

line. The ModivCare (formerly LogistiCare) staff determines where the driver is and ensures the participant is transported.

2. The WMR line may also be used when a participant is ready to return home after dialysis or any other medical appointment when the pickup time is not scheduled.
3. This line is also used when participants know they are going to be late. They should contact WMR or the designated provider immediately.
4. The WMR line is manned 24 hours a day, seven days a week and is available for questions or concerns with after hours' appointments.

22.21 QUALITY ASSURANCE (QA) PROCEDURE

Complaints may be filed by the MO HealthNet participant or by another person on behalf of the participant.

1. TP may also file a complaint against a participant should his/her behavior warrant such a complaint. ModivCare's (formerly LogistiCare) QA staff researches and resolves all complaints filed, and submits all information and outcomes to MHD. Complaints are filed through the WMR line. The FSWs and/or any facility representative can file a complaint to any ModivCare (formerly LogistiCare) representative by stating "I would like to file a complaint." As a part of the complaint investigation, it is noted whether the WMR line was utilized by facility or participant, with hopes of tracking issues immediately and avoiding situations which warrant complaints and to ensure appropriate transportation is received.
2. Participants also have the right to file a complaint through the MO HealthNet Participant Services Unit toll-free at 800-392-2161.

22.22 FREQUENTLY ASKED QUESTIONS

A. What is the policy on TP's notifying participants the night before a trip?

All transportation companies are required to attempt to contact the participant 24 hours in advance to inform the participant they will be the TP and the expected pick up time. In cases where TPs are not notifying the participants, the participant should call ModivCare (formerly LogistiCare) at 866-269-5944 and report this issue.

B. How are the drivers credentialed and trained for these trips?

All ModivCare (formerly LogistiCare) approved TPs are required to meet a rigorous credentialing process. This process mandates that all drivers must have a current driver's license, a clean driving record (including the Missouri State Highway Patrol Request for Criminal Record Check and the Family Care Safety Registry), and tested negative on a stringent drug test. Once all this information is received, ModivCare's (formerly

LogistiCare)'s Compliance Department will review it to make sure the driver meets all the standards set forth by the State of Missouri. The driver is then either approved or denied to transport participants for ModivCare (formerly LogistiCare).

Once approved to transport MO HealthNet NEMT participants, each driver must complete specific training related to NEMT transportation. Training, which is administered by the TP, includes several key topics: defensive driving; use of safety equipment; basic first aid and universal precautions for handling body fluids; operation of lifts, ramps and wheelchair securement devices; methods of handling wheelchairs; use of common assistive devices; methods of moving, lifting and transferring passengers with mobility limitations; and instructions on proper actions to be taken in problem situations.

C. Are the vehicles used for NEMT inspected on a regular basis?

Along with the driver credentialing process and training, each vehicle operated by a TP must undergo an initial 45 point vehicle inspection by a ModivCare (formerly LogistiCare) Field Monitor before that vehicle can be used to transport MO HealthNet NEMT participants. Once approved, each vehicle is reinspected every six months. Wheelchair and stretcher vehicles receive more in-depth inspections with regards to the special equipment needed for transport. Once inspected, a ModivCare (formerly LogistiCare) window decal is applied to the vehicle. This provides for a quick visual identification of a ModivCare (formerly LogistiCare) approved vehicle.

D. Who do I contact for reoccurring issues?

All issues should be reported to ModivCare (formerly LogistiCare) through the WMR line referenced above. For reoccurring issues, the ModivCare (formerly LogistiCare) Healthcare Manager or Ombudsman may be contacted at 866-269-4717.

E. Can a participant choose his/her TP?

A participant may request a preferred provider. ModivCare (formerly LogistiCare) will attempt to schedule transport with the preferred provider; however ModivCare (formerly LogistiCare) is unable to guarantee that the provider will be available for the specific trip.

F. Can a participant request not to ride with a specific TP?

A participant may request not to ride with a specific provider. ModivCare (formerly LogistiCare) will investigate any incident causing such a request.

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SECTION 23 - CLAIM ATTACHMENT SUBMISSION AND PROCESSING

This section of the manual provides examples and instructions for submitting claim attachments.

23.1 CLAIM ATTACHMENT SUBMISSIONS

Four claim attachments required for payment of certain services are separately processed from the claim form. The four attachments are:

- (Sterilization) Consent Form
- Acknowledgment of Receipt of Hysterectomy Information
- Medical Referral Form of Restricted Participant (PI-118)
- Certificate of Medical Necessity **(only for the Durable Medical Equipment Program)**

These attachments *should not* be submitted with a claim form. These attachments *should* be mailed separately to:

Wipro Infocrossing
P.O. Box 5900
Jefferson City, MO 65102

These attachments may also be submitted to Wipro Infocrossing via the Internet when additional documentation is *not* required. The web site address for these submissions is www.emomed.com.

The data from the attachment is entered into MO HealthNet Management Information System (MMIS) and processed for validity editing and MO HealthNet program requirements. Refer to specific manuals for program requirements.

Providers do *not* need to alter their claim submittal process or wait for an attachment to be finalized before submitting the corresponding claim(s) for payment. A claim for services requiring one of the listed attachments remains in suspense for up to 45 days. When an attachment can be systematically linked to the claim, the claim continues processing for adjudication. If after 45 days a match is *not* found, the claim denies for the missing attachment.

An approved attachment is valid only for the procedure code indicated on the attachment. If a change in procedure code occurs, a new attachment *must* be submitted incorporating the new procedure code.

23.2 CERTIFICATE OF MEDICAL NECESSITY FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY

The data from the Certificate of Medical Necessity for DME services is entered into MMIS and processed for validity editing and MO HealthNet program requirements. **DME providers are required to include the correct modifier (NU, RR, RB) in the procedure code field with the corresponding procedure code.**

A Certificate of Medical Necessity that has been submitted by a DME provider is reviewed and approved or denied. Denied requests may be resubmitted with additional information. If approved, a certificate of medical necessity is approved for six months from the prescription date. Any claim matching the criteria on the Certificate of Medical Necessity for that time period can be processed without submission of an additional Certificate of Medical Necessity. This includes all monthly claim submissions and any resubmissions.

END OF SECTION

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